BlueCross BlueShield of New Mexico

2024 Recommended Clinical Review , Post-Service Review and Non-Covered Procedure Code List - Fully Insured
Effective 1/1/2024
(Updated September 2024)

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System codes that, based on our medical policy, are: **- Subject to a medical necessity review,** **- Candidates for a Recommended Clinical Review,** **- Not a benefit for our members,** **- Considered experimental, investigational and unproven (EIU), or** **- Not on our prior authorization list (with some exceptions based on members' benefit plans)** **Except as otherwise noted in the date column, these codes are effective on or before January 1, 2024**	**Utilization Management Process** **This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.**

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.
	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).
Unlisted or Undefined	Procedures/services not specifically defined or classified, may be subject to contract/clinical review.

Note: Some codes will appear twice if Ending Date and Effective Date are within the same quarter period.

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2021	12/31/2999

11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2021	12/31/2999
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2005	12/31/2999
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2005	12/31/2999
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2006	12/31/2999
11970	Replacement of tissue expander with permanent implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2006	12/31/2999
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999

15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999

15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15758	Free fascial flap with microvascular anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2010	12/31/2999
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15776	Punch graft for hair transplant; more than 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999

15786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15824	Rhytidectomy; forehead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	1/31/2024
15824	Rhytidectomy; Forehead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

15826	Rhytidectomy; glabellar frown lines	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	1/31/2024
15826	Rhytidectomy; Glabellar Frown Lines	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024
15828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
15876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15879	Suction assisted lipectomy; lower extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
17360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

19294	Preparation Of Tumor Cavity With Placement Of A Radiation Therapy Applicator For Intraoperative Radiation Therapy (Iort) Concurrent With Partial Mastectomy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
19296	Placement Of Radiotherapy Afterloading Expandable Catheter (Single Or Multichannel) Into The Breast For Interstitial Radioelement Application Following Partial Mastectomy Includes Imaging Guidance; On Date Separate From Partial Mastectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
19297	Placement Of Radiotherapy Afterloading Expandable Catheter (Single Or Multichannel) Into The Breast For Interstitial Radioelement Application Following Partial Mastectomy Includes Imaging Guidance; Concurrent With Partial Mastectomy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
19298	Placement Of Radiotherapy After Loading Brachytherapy Catheters (Multiple Tube And Button Type) Into The Breast For Interstitial Radioelement Application Following (At The Time Of Or Subsequent To) Partial Mastectomy Includes Imaging Guidance	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
19300	Mastectomy for gynecomastia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
19303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
19316	Mastopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	4/14/2024
19316	Mastopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024

19318	Breast reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	1/31/2024
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024
19325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19342	Insertion or replacement of breast implant on separate day from mastectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2005	12/31/2999
19350	Nipple/areola reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19355	Correction of inverted nipples	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2006	12/31/2999
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999

20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
20555	Placement Of Needles Or Catheters Into Muscle And/Or Soft Tissue For Subsequent Interstitial Radioelement Application (At The Time Of Or Subsequent To The Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
20561	Needle insertion(s) without injection(s); 3 or more muscles	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
20930	Allograft Morselized Or Placement Of Osteopromotive Material For Spine Surgery Only (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20931	Allograft Structural For Spine Surgery Only (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20932	Allograft Includes Templating Cutting Placement And Internal Fixation When Performed; Osteoarticular Including Articular Surface And Contiguous Bone (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20933	Allograft Includes Templating Cutting Placement And Internal Fixation When Performed; Hemicortical Intercalary Partial (Ie Hemicylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20934	Allograft Includes Templating Cutting Placement And Internal Fixation When Performed; Intercalary Complete (Ie Cylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

20936	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Local (Eg Ribs Spinous Process Or Laminar Fragments) Obtained From Same Incision (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20937	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Morselized (Through Separate Skin Or Fascial Incision) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20938	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Structural Bicortical Or Tricortical (Through Separate Skin Or Fascial Incision) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20939	Bone Marrow Aspiration For Bone Grafting Spine Surgery Only Through Separate Skin Or Fascial Incision (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20974	Electrical Stimulation To Aid Bone Healing; Noninvasive (Nonoperative)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20975	Electrical Stimulation To Aid Bone Healing; Invasive (Operative)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	12/31/2999
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
21083	Impression and custom preparation; palatal lift prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21121	Genioplasty; sliding osteotomy, single piece	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21125	Augmentation, mandibular body or angle; prosthetic material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	4/14/2024
21125	Augmentation Mandibular Body Or Angle; Prosthetic Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	4/14/2024
21127	Augmentation Mandibular Body Or Angle; With Bone Graft Onlay Or Interpositional (Includes Obtaining Autograft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024

21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	2/14/2024
21145	Reconstruction Midface Lefort I; Single Piece Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	2/14/2024
21146	Reconstruction Midface Lefort I; 2 Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Unilateral Alveolar Cleft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	2/14/2024
21147	Reconstruction Midface Lefort I; 3 Or More Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Bilateral Alveolar Cleft Or Multiple Osteotomies)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21150	Reconstruction Midface Lefort Ii; Anterior Intrusion (Eg Treacher-Collins Syndrome)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024

21151	Reconstruction Midface Lefort Ii; Any Direction Requiring Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21154	Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21155	Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21159	Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21160	Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_

21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21188	Reconstruction Midface Osteotomies (Other Than Lefort Type) And Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21206	Osteotomy Maxilla Segmental (Eg Wassmund Or Schuchard)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21208	Osteoplasty Facial Bones; Augmentation (Autograft Allograft Or Prosthetic Implant)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21209	Osteoplasty, facial bones; reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	3/31/2024
21209	Osteoplasty Facial Bones; Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
22206	Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22207	Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22208	Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22210	Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22212	Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22214	Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22216	Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Each Additional Vertebral Segment (List Separately In Addition To Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22220	Osteotomy Of Spine Including Discectomy Anterior Approach Single Vertebral Segment; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22222	Osteotomy Of Spine Including Discectomy Anterior Approach Single Vertebral Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22224	Osteotomy Of Spine Including Discectomy Anterior Approach Single Vertebral Segment; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22226	Osteotomy Of Spine Including Discectomy Anterior Approach Single Vertebral Segment; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22505	Manipulation of spine requiring anesthesia, any region	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
22510	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Cervicothoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22511	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Lumbosacral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22512	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Each Additional Cervicothoracic Or Lumbosacral Vertebral Body (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22513	Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22514	Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22515	Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Each Additional Thoracic Or Lumbar Vertebral Body (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22532	Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22533	Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22534	Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic Or Lumbar Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22548	Arthrodesis Anterior Transoral Or Extraoral Technique Clivus-C1-C2 (Atlas-Axis) With Or Without Excision Of Odontoid Process	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22551	Arthrodesis Anterior Interbody Including Disc Space Preparation Discectomy Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22552	Arthrodesis Anterior Interbody Including Disc Space Preparation Discectomy Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2 Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22554	Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Cervical Below C2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22556	Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22558	Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22585	Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
22590	Arthrodesis Posterior Technique Craniocervical (Occiput-C2)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22595	Arthrodesis Posterior Technique Atlas-Axis (C1-C2)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22600	Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Cervical Below C2 Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22610	Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Thoracic (With Lateral Transverse Technique When Performed)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22612	Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Lumbar (With Lateral Transverse Technique When Performed)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22614	Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22630	Arthrodesis Posterior Interbody Technique Including Laminectomy And/Or Discectomy To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22632	Arthrodesis Posterior Interbody Technique Including Laminectomy And/Or Discectomy To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar; Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22633	Arthrodesis Combined Posterior Or Posterolateral Technique With Posterior Interbody Technique Including Laminectomy And/Or Discectomy Sufficient To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22634	Arthrodesis Combined Posterior Or Posterolateral Technique With Posterior Interbody Technique Including Laminectomy And/Or Discectomy Sufficient To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar; Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22800	Arthrodesis Posterior For Spinal Deformity With Or Without Cast; Up To 6 Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22802	Arthrodesis Posterior For Spinal Deformity With Or Without Cast; 7 To 12 Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22804	Arthrodesis Posterior For Spinal Deformity With Or Without Cast; 13 Or More Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22808	Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 2 To 3 Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22810	Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 4 To 7 Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22812	Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 8 Or More Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22818	Kyphectomy Circumferential Exposure Of Spine And Resection Of Vertebral Segment(S) (Including Body And Posterior Elements); Single Or 2 Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22819	Kyphectomy Circumferential Exposure Of Spine And Resection Of Vertebral Segment(S) (Including Body And Posterior Elements); 3 Or More Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22830	Exploration Of Spinal Fusion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22840	Posterior Non-Segmental Instrumentation (Eg Harrington Rod Technique Pedicle Fixation Across 1 Interspace Atlantoaxial Transarticular Screw Fixation Sublaminar Wiring At C1 Facet Screw Fixation) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22841	Internal Spinal Fixation By Wiring Of Spinous Processes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22842	Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 3 To 6 Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22843	Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 7 To 12 Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22844	Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 13 Or More Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22845	Anterior Instrumentation; 2 To 3 Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22846	Anterior Instrumentation; 4 To 7 Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22847	Anterior Instrumentation; 8 Or More Vertebral Segments (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22848	Pelvic Fixation (Attachment Of Caudal End Of Instrumentation To Pelvic Bony Structures) Other Than Sacrum (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22849	Reinsertion Of Spinal Fixation Device	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22853	Insertion Of Interbody Biomechanical Device(S) (Eg Synthetic Cage Mesh) With Integral Anterior Instrumentation For Device Anchoring (Eg Screws Flanges) When Performed To Intervertebral Disc Space In Conjunction With Interbody Arthrodesis Each Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22854	Insertion Of Intervertebral Biomechanical Device(S) (Eg Synthetic Cage Mesh) With Integral Anterior Instrumentation For Device Anchoring (Eg Screws Flanges) When Performed To Vertebral Corpectomy(Ies) (Vertebral Body Resection Partial Or Complete) Defect In Conjunction With Interbody Arthrodesis Each Contiguous Defect (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22856	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy With End Plate Preparation (Includes Osteophytectomy For Nerve Root Or Spinal Cord Decompression And Microdissection); Single Interspace Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22857	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy To Prepare Interspace (Other Than For Decompression); Single Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22858	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy With End Plate Preparation (Includes Osteophytectomy For Nerve Root Or Spinal Cord Decompression And Microdissection); Second Level Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

22859	Insertion Of Intervertebral Biomechanical Device(S) (Eg Synthetic Cage Mesh Methylmethacrylate) To Intervertebral Disc Space Or Vertebral Body Defect Without Interbody Arthrodesis Each Contiguous Defect (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22860	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy To Prepare Interspace (Other Than For Decompression); Second Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22861	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22862	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22864	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22865	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
23105	Arthrotomy; Glenohumeral Joint With Synovectomy With Or Without Biopsy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23107	Arthrotomy Glenohumeral Joint With Joint Exploration With Or Without Removal Of Loose Or Foreign Body	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23120	Claviculectomy; Partial	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23410	Repair Of Ruptured Musculotendinous Cuff (Eg Rotator Cuff) Open; Acute	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23412	Repair Of Ruptured Musculotendinous Cuff (Eg Rotator Cuff) Open; Chronic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23415	Coracoacromial Ligament Release With Or Without Acromioplasty	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23420	Reconstruction Of Complete Shoulder (Rotator) Cuff Avulsion Chronic (Includes Acromioplasty)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

23430	Tenodesis Of Long Tendon Of Biceps	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23440	Resection Or Transplantation Of Long Tendon Of Biceps	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23450	Capsulorrhaphy Anterior; Putti-Platt Procedure Or Magnuson Type Operation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23455	Capsulorrhaphy Anterior; With Labral Repair (Eg Bankart Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23460	Capsulorrhaphy Anterior Any Type; With Bone Block	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23462	Capsulorrhaphy Anterior Any Type; With Coracoid Process Transfer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23465	Capsulorrhaphy Glenohumeral Joint Posterior With Or Without Bone Block	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23466	Capsulorrhaphy Glenohumeral Joint Any Type Multidirectional Instability	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23470	Arthroplasty Glenohumeral Joint; Hemiarthroplasty	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23472	Arthroplasty Glenohumeral Joint; Total Shoulder (Glenoid And Proximal Humeral Replacement (Eg Total Shoulder))	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

23473	Revision Of Total Shoulder Arthroplasty Including Allograft When Performed; Humeral Or Glenoid Component	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23474	Revision Of Total Shoulder Arthroplasty Including Allograft When Performed; Humeral And Glenoid Component	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
23700	Manipulation Under Anesthesia Shoulder Joint Including Application Of Fixation Apparatus (Dislocation Excluded)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
24300	Manipulation, elbow, under anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
25259	Manipulation, wrist, under anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
26340	Manipulation, finger joint, under anesthesia, each joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
26341	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
27096	Injection Procedure For Sacroiliac Joint Anesthetic/Steroid With Image Guidance (Fluoroscopy Or Ct) Including Arthrography When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27120	Acetabuloplasty; (Eg Whitman Colonna Haygroves Or Cup Type)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27122	Acetabuloplasty; Resection Femoral Head (Eg Girdlestone Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

27125	Hemiarthroplasty Hip Partial (Eg Femoral Stem Prosthesis Bipolar Arthroplasty)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27130	Arthroplasty Acetabular And Proximal Femoral Prosthetic Replacement (Total Hip Arthroplasty) With Or Without Autograft Or Allograft	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27132	Conversion Of Previous Hip Surgery To Total Hip Arthroplasty With Or Without Autograft Or Allograft	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27134	Revision Of Total Hip Arthroplasty; Both Components With Or Without Autograft Or Allograft	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27137	Revision Of Total Hip Arthroplasty; Acetabular Component Only With Or Without Autograft Or Allograft	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27138	Revision Of Total Hip Arthroplasty; Femoral Component Only With Or Without Allograft	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27275	Manipulation, hip joint, requiring general anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2015	12/31/2999
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

27279	Arthrodesis Sacroiliac Joint Percutaneous Or Minimally Invasive (Indirect Visualization) With Image Guidance Includes Obtaining Bone Graft When Performed And Placement Of Transfixing Device	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27299	Unlisted procedure, pelvis or hip joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
27331	Arthrotomy Knee; Including Joint Exploration Biopsy Or Removal Of Loose Or Foreign Bodies	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
27332	Arthrotomy With Excision Of Semilunar Cartilage (Meniscectomy) Knee; Medial Or Lateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27333	Arthrotomy With Excision Of Semilunar Cartilage (Meniscectomy) Knee; Medial And Lateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27334	Arthrotomy With Synovectomy Knee; Anterior Or Posterior	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27335	Arthrotomy With Synovectomy Knee; Anterior And Posterior Including Popliteal Area	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27345	Excision Of Synovial Cyst Of Popliteal Space (Eg Baker'S Cyst)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27403	Arthrotomy With Meniscus Repair Knee	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27405	Repair Primary Torn Ligament And/Or Capsule Knee; Collateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

27407	Repair Primary Torn Ligament And/Or Capsule Knee; Cruciate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
27409	Repair Primary Torn Ligament And/Or Capsule Knee; Collateral And Cruciate Ligaments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
27415	Osteochondral Allograft Knee Open	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27416	Osteochondral Autograft(S) Knee Open (Eg Mosaicplasty) (Includes Harvesting Of Autograft[S])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27425	Lateral Retinacular Release Open	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27427	Ligamentous Reconstruction (Augmentation) Knee; Extra-Articular	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27428	Ligamentous Reconstruction (Augmentation) Knee; Intra-Articular (Open)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27429	Ligamentous Reconstruction (Augmentation) Knee; Intra-Articular (Open) And Extra-Articular	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27437	Arthroplasty Patella; Without Prosthesis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27438	Arthroplasty Patella; With Prosthesis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

27440	Arthroplasty Knee Tibial Plateau;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27441	Arthroplasty Knee Tibial Plateau; With Debridement And Partial Synovectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27442	Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27443	Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee; With Debridement And Partial Synovectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27445	Arthroplasty Knee Hinge Prosthesis (Eg Walldius Type)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27446	Arthroplasty Knee Condyle And Plateau; Medial Or Lateral Compartment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27447	Arthroplasty Knee Condyle And Plateau; Medial And Lateral Compartments With Or Without Patella Resurfacing (Total Knee Arthroplasty)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27486	Revision Of Total Knee Arthroplasty With Or Without Allograft; 1 Component	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27487	Revision Of Total Knee Arthroplasty With Or Without Allograft; Femoral And Entire Tibial Component	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
27488	Removal Of Prosthesis Including Total Knee Prosthesis Methylmethacrylate With Or Without Insertion Of Spacer Knee	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

27703	Arthroplasty, ankle; revision, total ankle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
28446	Open Osteochondral Autograft Talus (Includes Obtaining Graft[S])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
29440	Adding walker to previously applied cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
29805	Arthroscopy Shoulder Diagnostic With Or Without Synovial Biopsy (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29806	Arthroscopy Shoulder Surgical; Capsulorrhaphy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29807	Arthroscopy Shoulder Surgical; Repair Of Slap Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29819	Arthroscopy Shoulder Surgical; With Removal Of Loose Body Or Foreign Body	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29820	Arthroscopy Shoulder Surgical; Synovectomy Partial	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29821	Arthroscopy Shoulder Surgical; Synovectomy Complete	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

29822	Arthroscopy Shoulder Surgical; Debridement Limited 1 Or 2 Discrete Structures (Eg Humeral Bone Humeral Articular Cartilage Glenoid Bone Glenoid Articular Cartilage Biceps Tendon Biceps Anchor Complex Labrum Articular Capsule Articular Side Of The Rotator Cuff Bursal Side Of The Rotator Cuff Subacromial Bursa Foreign Body[Ies])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29823	Arthroscopy Shoulder Surgical; Debridement Extensive 3 Or More Discrete Structures (Eg Humeral Bone Humeral Articular Cartilage Glenoid Bone Glenoid Articular Cartilage Biceps Tendon Biceps Anchor Complex Labrum Articular Capsule Articular Side Of The Rotator Cuff Bursal Side Of The Rotator Cuff Subacromial Bursa Foreign Body[Ies])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29824	Arthroscopy Shoulder Surgical; Distal Claviculectomy Including Distal Articular Surface (Mumford Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29825	Arthroscopy Shoulder Surgical; With Lysis And Resection Of Adhesions With Or Without Manipulation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29826	Arthroscopy Shoulder Surgical; Decompression Of Subacromial Space With Partial Acromioplasty With Coracoacromial Ligament (Ie Arch) Release When Performed (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29827	Arthroscopy Shoulder Surgical; With Rotator Cuff Repair	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29828	Arthroscopy Shoulder Surgical; Biceps Tenodesis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

29860	Arthroscopy Hip Diagnostic With Or Without Synovial Biopsy (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29861	Arthroscopy Hip Surgical; With Removal Of Loose Body Or Foreign Body	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29862	Arthroscopy Hip Surgical; With Debridement/Shaving Of Articular Cartilage (Chondroplasty) Abrasion Arthroplasty And/Or Resection Of Labrum	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29863	Arthroscopy Hip Surgical; With Synovectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2020	12/31/2999
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
29867	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg Mosaicplasty)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29868	Arthroscopy Knee Surgical; Meniscal Transplantation (Includes Arthrotomy For Meniscal Insertion) Medial Or Lateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29870	Arthroscopy Knee Diagnostic With Or Without Synovial Biopsy (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29871	Arthroscopy Knee Surgical; For Infection Lavage And Drainage	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

29873	Arthroscopy Knee Surgical; With Lateral Release	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29874	Arthroscopy Knee Surgical; For Removal Of Loose Body Or Foreign Body (Eg Osteochondritis Dissecans Fragmentation Chondral Fragmentation)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29875	Arthroscopy Knee Surgical; Synovectomy Limited (Eg Plica Or Shelf Resection) (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29876	Arthroscopy Knee Surgical; Synovectomy Major 2 Or More Compartments (Eg Medial Or Lateral)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29877	Arthroscopy Knee Surgical; Debridement/Shaving Of Articular Cartilage (Chondroplasty)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29879	Arthroscopy Knee Surgical; Abrasion Arthroplasty (Includes Chondroplasty Where Necessary) Or Multiple Drilling Or Microfracture	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29880	Arthroscopy Knee Surgical; With Meniscectomy (Medial And Lateral Including Any Meniscal Shaving) Including Debridement/Shaving Of Articular Cartilage (Chondroplasty) Same Or Separate Compartment(S) When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29881	Arthroscopy Knee Surgical; With Meniscectomy (Medial Or Lateral Including Any Meniscal Shaving) Including Debridement/Shaving Of Articular Cartilage (Chondroplasty) Same Or Separate Compartment(S) When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29882	Arthroscopy Knee Surgical; With Meniscus Repair (Medial Or Lateral)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

29883	Arthroscopy Knee Surgical; With Meniscus Repair (Medial And Lateral)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29884	Arthroscopy Knee Surgical; With Lysis Of Adhesions With Or Without Manipulation (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29885	Arthroscopy Knee Surgical; Drilling For Osteochondritis Dissecans With Bone Grafting With Or Without Internal Fixation (Including Debridement Of Base Of Lesion)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29886	Arthroscopy Knee Surgical; Drilling For Intact Osteochondritis Dissecans Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29887	Arthroscopy Knee Surgical; Drilling For Intact Osteochondritis Dissecans Lesion With Internal Fixation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29888	Arthroscopically Aided Anterior Cruciate Ligament Repair/Augmentation Or Reconstruction	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29889	Arthroscopically Aided Posterior Cruciate Ligament Repair/Augmentation Or Reconstruction	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29892	Arthroscopically Aided Repair Of Large Osteochondritis Dissecans Lesion Talar Dome Fracture Or Tibial Plafond Fracture With Or Without Internal Fixation (Includes Arthroscopy)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999

29916	Arthroscopy, hip, surgical; with labral repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
30999	Unlisted Procedure Nose	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
31299	Unlisted Procedure Accessory Sinuses	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
31643	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Placement Of Catheter(S) For Intracavitary Radioelement Application	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

32701	Thoracic Target(S) Delineation For Stereotactic Body Radiation Therapy (Srs/Sbrt) (Photon Or Particle Beam) Entire Course Of Treatment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2020	12/31/2999

33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2020	12/31/2999
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33542	Myocardial resection (eg, ventricular aneurysmectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999

36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999

36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36516	Therapeutic Apheresis; With Extracorporeal Immunoadsorption Selective Adsorption Or Selective Filtration And Plasma Reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2014	12/31/2999
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37718	Ligation, division, and stripping, short saphenous vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999

37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	1/31/2024
38206	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38230	Bone marrow harvesting for transplantation; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	1/31/2024
38230	Bone Marrow Harvesting For Transplantation; Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
38232	Bone marrow harvesting for transplantation; autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	1/31/2024
38241	Hematopoietic Progenitor Cell (Hpc); Autologous Transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
38242	Allogeneic lymphocyte infusions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

38243	Hematopoietic progenitor cell (HPC); HPC boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38308	Lymphangiotomy or other operations on lymphatic channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2014	12/31/2999
41019	Placement Of Needles Catheters Or Other Device(S) Into The Head And/Or Neck Region (Percutaneous Transoral Or Transnasal) For Subsequent Interstitial Radioelement Application	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	3/31/2024
41820	Gingivectomy, excision gingiva, each quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41821	Operculectomy, excision pericoronal tissues	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41822	Excision of fibrous tuberosities, dentoalveolar structures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41823	Excision of osseous tuberosities, dentoalveolar structures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41870	Periodontal mucosal grafting	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41872	Gingivoplasty, each quadrant (specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
41874	Alveoloplasty, each quadrant (specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
42140	Uvulectomy, excision of uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999

43289	Unlisted laparoscopy procedure, esophagus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
43632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999

43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2009	12/31/2999
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999

46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2017	12/31/2999
50541	Laparoscopy, surgical; ablation of renal cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	12/31/2999
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	12/31/2999
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2020	5/14/2024
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
54125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
54200	Injection procedure for Peyronie disease;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2010	12/31/2999
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2010	12/31/2999
54235	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2007	12/31/2999
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
54401	Insertion of penile prosthesis; inflatable (self-contained)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
54660	Insertion of testicular prosthesis (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
55860	Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
55862	Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance; With Lymph Node Biopsy(S) (Limited Pelvic Lymphadenectomy)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
55865	Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance; With Bilateral Pelvic Lymphadenectomy Including External Iliac Hypogastric And Obturator Nodes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

55874	Transperineal Placement Of Biodegradable Material Peri-Prostatic Single Or Multiple Injection(S) Including Image Guidance When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
55875	Transperineal Placement Of Needles Or Catheters Into Prostate For Interstitial Radioelement Application With Or Without Cystoscopy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
55899	Unlisted procedure, male genital system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
55920	Placement Of Needles Or Catheters Into Pelvic Organs And/Or Genitalia (Except Prostate) For Subsequent Interstitial Radioelement Application	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
55970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
55980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
56805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
57155	Insertion Of Uterine Tandem And/Or Vaginal Ovoids For Clinical Brachytherapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
57156	Insertion Of A Vaginal Radiation Afterloading Apparatus For Clinical Brachytherapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

57291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
58346	Insertion Of Heyman Capsules For Clinical Brachytherapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
59072	Fetal umbilical cord occlusion, including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
59076	Fetal shunt placement, including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
60699	Unlisted procedure, endocrine system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999

61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
61796	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Simple Cranial Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
61797	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Cranial Lesion Simple (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
61798	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Complex Cranial Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

61799	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Cranial Lesion Complex (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
61800	Application Of Stereotactic Headframe For Stereotactic Radiosurgery (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
62280	Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Subarachnoid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

62281	Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Epidural Cervical Or Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62282	Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Epidural Lumbar Sacral (Caudal)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
62292	Injection Procedure For Chemonucleolysis Including Discography Intervertebral Disc Single Or Multiple Levels Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62320	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Including Needle Or Catheter Placement Interlaminar Epidural Or Subarachnoid Cervical Or Thoracic; Without Imaging Guidance	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62321	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Including Needle Or Catheter Placement Interlaminar Epidural Or Subarachnoid Cervical Or Thoracic; With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

62322	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Including Needle Or Catheter Placement Interlaminar Epidural Or Subarachnoid Lumbar Or Sacral (Caudal); Without Imaging Guidance	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62323	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Including Needle Or Catheter Placement Interlaminar Epidural Or Subarachnoid Lumbar Or Sacral (Caudal); With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62325	Injection(S) Including Indwelling Catheter Placement Continuous Infusion Or Intermittent Bolus Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Interlaminar Epidural Or Subarachnoid Cervical Or Thoracic; With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62327	Injection(S) Including Indwelling Catheter Placement Continuous Infusion Or Intermittent Bolus Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Interlaminar Epidural Or Subarachnoid Lumbar Or Sacral (Caudal); With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

62350	Implantation Revision Or Repositioning Of Tunneled Intrathecal Or Epidural Catheter For Long-Term Medication Administration Via An External Pump Or Implantable Reservoir/Infusion Pump; Without Laminectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62351	Implantation Revision Or Repositioning Of Tunneled Intrathecal Or Epidural Catheter For Long-Term Medication Administration Via An External Pump Or Implantable Reservoir/Infusion Pump; With Laminectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62360	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Subcutaneous Reservoir	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62361	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Nonprogrammable Pump	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62362	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Programmable Pump Including Preparation Of Pump With Or Without Programming	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
62380	Endoscopic Decompression Of Spinal Cord Nerve Root(S) Including Laminotomy Partial Facetectomy Foraminotomy Discectomy And/Or Excision Of Herniated Intervertebral Disc 1 Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63001	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63003	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63005	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Lumbar Except For Spondylolisthesis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63012	Laminectomy With Removal Of Abnormal Facets And/Or Pars Inter-Articularis With Decompression Of Cauda Equina And Nerve Roots For Spondylolisthesis Lumbar (Gill Type Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63015	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63016	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63017	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63020	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; 1 Interspace Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63030	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; 1 Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63035	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; Each Additional Interspace Cervical Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63040	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63042	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63043	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Each Additional Cervical Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63044	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Each Additional Lumbar Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63045	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63046	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63047	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63048	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Each Additional Vertebral Segment Cervical Thoracic Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63050	Laminoplasty Cervical With Decompression Of The Spinal Cord 2 Or More Vertebral Segments;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63051	Laminoplasty Cervical With Decompression Of The Spinal Cord 2 Or More Vertebral Segments; With Reconstruction Of The Posterior Bony Elements (Including The Application Of Bridging Bone Graft And Non-Segmental Fixation Devices [Eg Wire Suture Mini-Plates] When Performed)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63052	Laminectomy Facetectomy Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) During Posterior Interbody Arthrodesis Lumbar; Single Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63053	Laminectomy Facetectomy Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) During Posterior Interbody Arthrodesis Lumbar; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63055	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63056	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Lumbar (Including Transfacet Or Lateral Extraforaminal Approach) (Eg Far Lateral Herniated Intervertebral Disc)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63057	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Each Additional Segment Thoracic Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63075	Discectomy Anterior With Decompression Of Spinal Cord And/Or Nerve Root(S) Including Osteophytectomy; Cervical Single Interspace	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63076	Discectomy Anterior With Decompression Of Spinal Cord And/Or Nerve Root(S) Including Osteophytectomy; Cervical Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63081	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Anterior Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Cervical Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63082	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Anterior Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Cervical Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63085	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transthoracic Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Thoracic Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63086	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transthoracic Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Thoracic Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63087	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Combined Thoracolumbar Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Or Lumbar; Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63088	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Combined Thoracolumbar Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Or Lumbar; Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63090	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transperitoneal Or Retroperitoneal Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Lumbar Or Sacral; Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63091	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transperitoneal Or Retroperitoneal Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Lumbar Or Sacral; Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63101	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Thoracic Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63102	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Lumbar Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63103	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Thoracic Or Lumbar Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63185	Laminectomy With Rhizotomy; 1 Or 2 Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63190	Laminectomy With Rhizotomy; More Than 2 Segments	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63191	Laminectomy With Section Of Spinal Accessory Nerve	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63200	Laminectomy With Release Of Tethered Spinal Cord Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63250	Laminectomy For Excision Or Occlusion Of Arteriovenous Malformation Of Spinal Cord; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63252	Laminectomy For Excision Or Occlusion Of Arteriovenous Malformation Of Spinal Cord; Thoracolumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63265	Laminectomy For Excision Or Evacuation Of Intraspinal Lesion Other Than Neoplasm Extradural; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63267	Laminectomy For Excision Or Evacuation Of Intraspinal Lesion Other Than Neoplasm Extradural; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63270	Laminectomy For Excision Of Intraspinal Lesion Other Than Neoplasm Intradural; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63272	Laminectomy For Excision Of Intraspinal Lesion Other Than Neoplasm Intradural; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63275	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Extradural Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63277	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Extradural Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63280	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Extramedullary Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63282	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Extramedullary Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63285	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Intramedullary Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63287	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Intramedullary Thoracolumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63290	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Combined Extradural-Intradural Lesion Any Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63300	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63301	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Thoracic By Transthoracic Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63302	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Thoracic By Thoracolumbar Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63303	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Lumbar Or Sacral By Transperitoneal Or Retroperitoneal Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63304	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63305	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Thoracic By Transthoracic Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63306	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Thoracic By Thoracolumbar Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63307	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Lumbar Or Sacral By Transperitoneal Or Retroperitoneal Approach	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63308	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Each Additional Segment (List Separately In Addition To Codes For Single Segment)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63620	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Spinal Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63621	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Spinal Lesion (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63650	Percutaneous Implantation Of Neurostimulator Electrode Array Epidural	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63655	Laminectomy For Implantation Of Neurostimulator Electrodes Plate/Paddle Epidural	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63663	Revision Including Replacement When Performed Of Spinal Neurostimulator Electrode Percutaneous Array(S) Including Fluoroscopy When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

63664	Revision Including Replacement When Performed Of Spinal Neurostimulator Electrode Plate/Paddle(S) Placed Via Laminotomy Or Laminectomy Including Fluoroscopy When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63685	Insertion Or Replacement Of Spinal Neurostimulator Pulse Generator Or Receiver Requiring Pocket Creation And Connection Between Electrode Array And Pulse Generator Or Receiver	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
63688	Revision Or Removal Of Implanted Spinal Neurostimulator Pulse Generator Or Receiver With Detachable Connection To Electrode Array	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64451	Injection(S) Anesthetic Agent(S) And/Or Steroid; Nerves Innervating The Sacroiliac Joint With Image Guidance (Ie Fluoroscopy Or Computed Tomography)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64479	Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64480	Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic Each Additional Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64483	Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64484	Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral Each Additional Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

64490	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64491	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64492	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64493	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64494	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64495	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64510	Injection Anesthetic Agent; Stellate Ganglion (Cervical Sympathetic)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

64520	Injection Anesthetic Agent; Lumbar Or Thoracic (Paravertebral Sympathetic)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	3/31/2024
64582	Open Implantation Of Hypoglossal Nerve Neurostimulator Array Pulse Generator And Distal Respiratory Sensor Electrode Or Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	3/31/2024
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999

64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
64625	Radiofrequency Ablation Nerves Innervating The Sacroiliac Joint With Image Guidance (Ie Fluoroscopy Or Computed Tomography)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
64633	Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic Single Facet Joint	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64634	Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic Each Additional Facet Joint (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64635	Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral Single Facet Joint	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64636	Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral Each Additional Facet Joint (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
64640	Destruction by neurolytic agent; other peripheral nerve or branch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999

64999	Unlisted Procedure Nervous System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
65785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2022	12/31/2999
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2022	12/31/2999
67027	Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
67218	Destruction Of Localized Lesion Of Retina (Eg Macular Edema Tumors) 1 Or More Sessions; Radiation By Implantation Of Source (Includes Removal Of Source)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	2/14/2024

67900	Repair Of Brow Ptosis (Supraciliary Mid-Forehead Or Coronal Approach)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
69090	Ear piercing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
69300	Otoplasty, protruding ear, with or without size reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

69714	Implantation Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2022	12/31/2999
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
69717	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2022	12/31/2999
69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999

69930	Cochlear Device Implantation With Or Without Mastoidectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
76873	Ultrasound Transrectal; Prostate Volume Study For Brachytherapy Treatment Planning (Separate Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
76965	Ultrasonic Guidance For Interstitial Radioelement Application	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77014	Computed Tomography Guidance For Placement Of Radiation Therapy Fields	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77295	3-Dimensional Radiotherapy Plan Including Dose-Volume Histograms	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77301	Intensity Modulated Radiotherapy Plan Including Dose-Volume Histograms For Target And Critical Structure Partial Tolerance Specifications	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77316	Brachytherapy Isodose Plan; Simple (Calculation[S] Made From 1 To 4 Sources Or Remote Afterloading Brachytherapy 1 Channel) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77317	Brachytherapy Isodose Plan; Intermediate (Calculation[S] Made From 5 To 10 Sources Or Remote Afterloading Brachytherapy 2-12 Channels) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

77318	Brachytherapy Isodose Plan; Complex (Calculation[S] Made From Over 10 Sources Or Remote Afterloading Brachytherapy Over 12 Channels) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77338	Multi-Leaf Collimator (Mlc) Device(S) For Intensity Modulated Radiation Therapy (Imrt) Design And Construction Per Imrt Plan	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77370	Special Medical Radiation Physics Consultation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77371	Radiation Treatment Delivery Stereotactic Radiosurgery (Srs) Complete Course Of Treatment Of Cranial Lesion(S) Consisting Of 1 Session; Multi-Source Cobalt 60 Based	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77372	Radiation Treatment Delivery Stereotactic Radiosurgery (Srs) Complete Course Of Treatment Of Cranial Lesion(S) Consisting Of 1 Session; Linear Accelerator Based	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77373	Stereotactic Body Radiation Therapy Treatment Delivery Per Fraction To 1 Or More Lesions Including Image Guidance Entire Course Not To Exceed 5 Fractions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77385	Intensity Modulated Radiation Treatment Delivery (Imrt) Includes Guidance And Tracking When Performed; Simple	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77386	Intensity Modulated Radiation Treatment Delivery (Imrt) Includes Guidance And Tracking When Performed; Complex	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77387	Guidance For Localization Of Target Volume For Delivery Of Radiation Treatment Includes Intrafraction Tracking When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77402	Radiation Treatment Delivery >=1 Mev; Simple	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

77407	Radiation Treatment Delivery >=1 Mev; Intermediate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77412	Radiation Treatment Delivery >=1 Mev; Complex	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77424	Intraoperative Radiation Treatment Delivery X-Ray Single Treatment Session	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77425	Intraoperative Radiation Treatment Delivery Electrons Single Treatment Session	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77432	Stereotactic Radiation Treatment Management Of Cranial Lesion(S) (Complete Course Of Treatment Consisting Of 1 Session)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77435	Stereotactic Body Radiation Therapy Treatment Management Per Treatment Course To 1 Or More Lesions Including Image Guidance Entire Course Not To Exceed 5 Fractions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77469	Intraoperative Radiation Treatment Management	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77470	Special Treatment Procedure (Eg Total Body Irradiation Hemibody Radiation Per Oral Or Endocavitary Irradiation)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77520	Proton Treatment Delivery; Simple Without Compensation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77522	Proton Treatment Delivery; Simple With Compensation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

77523	Proton Treatment Delivery; Intermediate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77525	Proton Treatment Delivery; Complex	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77750	Infusion Or Instillation Of Radioelement Solution (Includes 3-Month Follow-Up Care)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77761	Intracavitary Radiation Source Application; Simple	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77762	Intracavitary Radiation Source Application; Intermediate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77763	Intracavitary Radiation Source Application; Complex	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77767	Remote Afterloading High Dose Rate Radionuclide Skin Surface Brachytherapy Includes Basic Dosimetry When Performed; Lesion Diameter Up To 2.0 Cm Or 1 Channel	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77768	Remote Afterloading High Dose Rate Radionuclide Skin Surface Brachytherapy Includes Basic Dosimetry When Performed; Lesion Diameter Over 2.0 Cm And 2 Or More Channels Or Multiple Lesions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77770	Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; 1 Channel	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77771	Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; 2-12 Channels	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

77772	Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; Over 12 Channels	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77778	Interstitial Radiation Source Application Complex Includes Supervision Handling Loading Of Radiation Source When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
77790	Supervision Handling Loading Of Radiation Source	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
79101	Radiopharmaceutical Therapy By Intravenous Administration	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
79403	Radiopharmaceutical Therapy Radiolabeled Monoclonal Antibody By Intravenous Infusion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81163	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81164	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Duplication/Deletion Analysis (Ie Detection Of Large Gene Rearrangements)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81165	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81166	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Duplication/Deletion Analysis (Ie Detection Of Large Gene Rearrangements)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81167	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Duplication/Deletion Analysis (Ie Detection Of Large Gene Rearrangements)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81168	Ccnd1/Igh (T(11;14)) (Eg Mantle Cell Lymphoma) Translocation Analysis Major Breakpoint Qualitative And Quantitative If Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81170	Abl1 (Abl Proto-Oncogene 1 Non-Receptor Tyrosine Kinase) (Eg Acquired Imatinib Tyrosine Kinase Inhibitor Resistance) Gene Analysis Variants In The Kinase Domain	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81171	Aff2 (Alf Transcription Elongation Factor 2 [Fmr2]) (Eg Fragile X Intellectual Disability 2 [Fraxe]) Gene Analysis; Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81172	Aff2 (Alf Transcription Elongation Factor 2 [Fmr2]) (Eg Fragile X Intellectual Disability 2 [Fraxe]) Gene Analysis; Characterization Of Alleles (Eg Expanded Size And Methylation Status)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81173	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81174	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81175	Asxl1 (Additional Sex Combs Like 1 Transcriptional Regulator) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms Chronic Myelomonocytic Leukemia) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81176	Asxl1 (Additional Sex Combs Like 1 Transcriptional Regulator) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms Chronic Myelomonocytic Leukemia) Gene Analysis; Targeted Sequence Analysis (Eg Exon 12)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81177	Atn1 (Atrophin 1) (Eg Dentatorubral-Pallidoluysian Atrophy) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81178	Atxn1 (Ataxin 1) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81179	Atxn2 (Ataxin 2) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81180	Atxn3 (Ataxin 3) (Eg Spinocerebellar Ataxia Machado-Joseph Disease) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81181	Atxn7 (Ataxin 7) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81182	Atxn8Os (Atxn8 Opposite Strand [Non-Protein Coding]) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81183	Atxn10 (Ataxin 10) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81184	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (Eg Spinocerebellar Ataxia) Gene Analysis; Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81185	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (Eg Spinocerebellar Ataxia) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81186	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (Eg Spinocerebellar Ataxia) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81187	Cnbp (Cchc-Type Zinc Finger Nucleic Acid Binding Protein) (Eg Myotonic Dystrophy Type 2) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81188	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene Analysis; Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81189	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81190	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene Analysis; Known Familial Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81191	Ntrk1 (Neurotrophic Receptor Tyrosine Kinase 1) (Eg Solid Tumors) Translocation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81192	Ntrk2 (Neurotrophic Receptor Tyrosine Kinase 2) (Eg Solid Tumors) Translocation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81193	Ntrk3 (Neurotrophic Receptor Tyrosine Kinase 3) (Eg Solid Tumors) Translocation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81194	Ntrk (Neurotrophic Receptor Tyrosine Kinase 1 2 And 3) (Eg Solid Tumors) Translocation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81200	Aspa (Aspartoacylase) (Eg Canavan Disease) Gene Analysis Common Variants (Eg E285A Y231X)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81201	Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81202	Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81203	Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81204	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) Gene Analysis; Characterization Of Alleles (Eg Expanded Size Or Methylation Status)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81205	Bckdhb (Branched-Chain Keto Acid Dehydrogenase E1 Beta Polypeptide) (Eg Maple Syrup Urine Disease) Gene Analysis Common Variants (Eg R183P G278S E422X)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81208	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis; Other Breakpoint Qualitative Or Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81209	Blm (Bloom Syndrome Recq Helicase-Like) (Eg Bloom Syndrome) Gene Analysis 2281Del6Ins7 Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81210	Braf (B-Raf Proto-Oncogene Serine/Threonine Kinase) (Eg Colon Cancer Melanoma) Gene Analysis V600 Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81212	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; 185Delag 5385Insc 6174Delt Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81215	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81216	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81217	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81218	Cebpa (Ccaat/Enhancer Binding Protein [C/Ebp] Alpha) (Eg Acute Myeloid Leukemia) Gene Analysis Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81219	Calr (Calreticulin) (Eg Myeloproliferative Disorders) Gene Analysis Common Variants In Exon 9	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81221	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81222	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81223	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81224	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) Gene Analysis; Intron 8 Poly-T Analysis (Eg Male Infertility)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81225	Cyp2C19 (Cytochrome P450 Family 2 Subfamily C Polypeptide 19) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *8 *17)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81226	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *5 *6 *9 *10 *17 *19 *29 *35 *41 *1Xn *2Xn *4Xn)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81227	Cyp2C9 (Cytochrome P450 Family 2 Subfamily C Polypeptide 9) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *5 *6)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81228	Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number Variants Comparative Genomic Hybridization [Cgh] Microarray Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81229	Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number And Single Nucleotide Polymorphism (Snp) Variants Comparative Genomic Hybridization (Cgh) Microarray Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81230	Cyp3A4 (Cytochrome P450 Family 3 Subfamily A Member 4) (Eg Drug Metabolism) Gene Analysis Common Variant(S) (Eg *2 *22)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81231	Cyp3A5 (Cytochrome P450 Family 3 Subfamily A Member 5) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *5 *6 *7)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81232	Dpyd (Dihydropyrimidine Dehydrogenase) (Eg 5-Fluorouracil/5-Fu And Capecitabine Drug Metabolism) Gene Analysis Common Variant(S) (Eg *2A *4 *5 *6)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81233	Btk (Bruton'S Tyrosine Kinase) (Eg Chronic Lymphocytic Leukemia) Gene Analysis Common Variants (Eg C481S C481R C481F)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81234	Dmpk (Dm1 Protein Kinase) (Eg Myotonic Dystrophy Type 1) Gene Analysis; Evaluation To Detect Abnormal (Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81235	Egfr (Epidermal Growth Factor Receptor) (Eg Non-Small Cell Lung Cancer) Gene Analysis Common Variants (Eg Exon 19 Lrea Deletion L858R T790M G719A G719S L861Q)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81236	Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2 Subunit) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms) Gene Analysis Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81237	Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2 Subunit) (Eg Diffuse Large B-Cell Lymphoma) Gene Analysis Common Variant(S) (Eg Codon 646)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81238	F9 (Coagulation Factor Ix) (Eg Hemophilia B) Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81239	Dmpk (Dm1 Protein Kinase) (Eg Myotonic Dystrophy Type 1) Gene Analysis; Characterization Of Alleles (Eg Expanded Size)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81240	F2 (Prothrombin Coagulation Factor Ii) (Eg Hereditary Hypercoagulability) Gene Analysis 20210G>A Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81242	Fancc (Fanconi Anemia Complementation Group C) (Eg Fanconi Anemia Type C) Gene Analysis Common Variant (Eg Ivs4+4A>T)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81244	Fmr1 (Fragile X Messenger Ribonucleoprotein 1) (Eg Fragile X Syndrome X-Linked Intellectual Disability [Xlid]) Gene Analysis; Characterization Of Alleles (Eg Expanded Size And Promoter Methylation Status)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81245	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Gene Analysis; Internal Tandem Duplication (Itd) Variants (Ie Exons 14 15)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81246	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Gene Analysis; Tyrosine Kinase Domain (Tkd) Variants (Eg D835 I836)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81247	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) Gene Analysis; Common Variant(S) (Eg A A-)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81248	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) Gene Analysis; Known Familial Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81249	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81250	G6Pc (Glucose-6-Phosphatase Catalytic Subunit) (Eg Glycogen Storage Disease Type 1A Von Gierke Disease) Gene Analysis Common Variants (Eg R83C Q347X)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81251	Gba (Glucosidase Beta Acid) (Eg Gaucher Disease) Gene Analysis Common Variants (Eg N370S 84Gg L444P Ivs2+1G>A)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81252	Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg Nonsyndromic Hearing Loss) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81253	Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg Nonsyndromic Hearing Loss) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81254	Gjb6 (Gap Junction Protein Beta 6 30Kda Connexin 30) (Eg Nonsyndromic Hearing Loss) Gene Analysis Common Variants (Eg 309Kb [Del(Gjb6-D13S1830)] And 232Kb [Del(Gjb6-D13S1854)])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81255	Hexa (Hexosaminidase A [Alpha Polypeptide]) (Eg Tay-Sachs Disease) Gene Analysis Common Variants (Eg 1278Instatc 1421+1G>C G269S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81256	Hfe (Hemochromatosis) (Eg Hereditary Hemochromatosis) Gene Analysis Common Variants (Eg C282Y H63D)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81257	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) Gene Analysis; Common Deletions Or Variant (Eg Southeast Asian Thai Filipino Mediterranean Alpha3.7 Alpha4.2 Alpha20.5 Constant Spring)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81258	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81259	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81260	Ikbkap (Inhibitor Of Kappa Light Polypeptide Gene Enhancer In B-Cells Kinase Complex-Associated Protein) (Eg Familial Dysautonomia) Gene Analysis Common Variants (Eg 2507+6T>C R696P)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81261	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias And Lymphomas B-Cell) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Amplified Methodology (Eg Polymerase Chain Reaction)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81262	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias And Lymphomas B-Cell) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Direct Probe Methodology (Eg Southern Blot)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81263	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemia And Lymphoma B-Cell) Variable Region Somatic Mutation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81264	Igk@ (Immunoglobulin Kappa Light Chain Locus) (Eg Leukemia And Lymphoma B-Cell) Gene Rearrangement Analysis Evaluation To Detect Abnormal Clonal Population(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81265	Comparative Analysis Using Short Tandem Repeat (Str) Markers; Patient And Comparative Specimen (Eg Pre-Transplant Recipient And Donor Germline Testing Post-Transplant Non-Hematopoietic Recipient Germline [Eg Buccal Swab Or Other Germline Tissue Sample] And Donor Testing Twin Zygosity Testing Or Maternal Cell Contamination Of Fetal Cells)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81266	Comparative Analysis Using Short Tandem Repeat (Str) Markers; Each Additional Specimen (Eg Additional Cord Blood Donor Additional Fetal Samples From Different Cultures Or Additional Zygosity In Multiple Birth Pregnancies) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81269	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81270	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene Analysis P.Val617Phe (V617F) Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81271	Htt (Huntingtin) (Eg Huntington Disease) Gene Analysis; Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81272	Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene Homolog) (Eg Gastrointestinal Stromal Tumor [Gist] Acute Myeloid Leukemia Melanoma) Gene Analysis Targeted Sequence Analysis (Eg Exons 8 11 13 17 18)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81273	Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene Homolog) (Eg Mastocytosis) Gene Analysis D816 Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81274	Htt (Huntingtin) (Eg Huntington Disease) Gene Analysis; Characterization Of Alleles (Eg Expanded Size)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81275	Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg Carcinoma) Gene Analysis; Variants In Exon 2 (Eg Codons 12 And 13)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81276	Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg Carcinoma) Gene Analysis; Additional Variant(S) (Eg Codon 61 Codon 146)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81277	Cytogenomic Neoplasia (Genome-Wide) Microarray Analysis Interrogation Of Genomic Regions For Copy Number And Loss-Of-Heterozygosity Variants For Chromosomal Abnormalities	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81278	Igh@/Bcl2 (T(14;18)) (Eg Follicular Lymphoma) Translocation Analysis Major Breakpoint Region (Mbr) And Minor Cluster Region (Mcr) Breakpoints Qualitative Or Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81279	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Targeted Sequence Analysis (Eg Exons 12 And 13)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81283	Ifnl3 (Interferon Lambda 3) (Eg Drug Response) Gene Analysis Rs12979860 Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81284	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Evaluation To Detect Abnormal (Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81285	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Characterization Of Alleles (Eg Expanded Size)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81286	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81287	Mgmt (O-6-Methylguanine-Dna Methyltransferase) (Eg Glioblastoma Multiforme) Promoter Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81288	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Promoter Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81289	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Known Familial Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81290	Mcoln1 (Mucolipin 1) (Eg Mucolipidosis Type Iv) Gene Analysis Common Variants (Eg Ivs3-2A>G Del6.4Kb)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81291	Mthfr (5 10-Methylenetetrahydrofolate Reductase) (Eg Hereditary Hypercoagulability) Gene Analysis Common Variants (Eg 677T 1298C)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81292	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81293	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81294	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81295	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81296	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81297	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81298	Msh6 (Muts Homolog 6 [E. Coli]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81299	Msh6 (Muts Homolog 6 [E. Coli]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81300	Msh6 (Muts Homolog 6 [E. Coli]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81301	Microsatellite Instability Analysis (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Of Markers For Mismatch Repair Deficiency (Eg Bat25 Bat26) Includes Comparison Of Neoplastic And Normal Tissue If Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81302	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81303	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81304	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81305	Myd88 (Myeloid Differentiation Primary Response 88) (Eg Waldenstrom'S Macroglobulinemia Lymphoplasmacytic Leukemia) Gene Analysis P.Leu265Pro (L265P) Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81306	Nudt15 (Nudix Hydrolase 15) (Eg Drug Metabolism) Gene Analysis Common Variant(S) (Eg *2 *3 *4 *5 *6)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81307	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And Pancreatic Cancer) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81308	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And Pancreatic Cancer) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81309	Pik3Ca (Phosphatidylinositol-4 5-Biphosphate 3-Kinase Catalytic Subunit Alpha) (Eg Colorectal And Breast Cancer) Gene Analysis Targeted Sequence Analysis (Eg Exons 7 9 20)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81310	Npm1 (Nucleophosmin) (Eg Acute Myeloid Leukemia) Gene Analysis Exon 12 Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81311	Nras (Neuroblastoma Ras Viral [V-Ras] Oncogene Homolog) (Eg Colorectal Carcinoma) Gene Analysis Variants In Exon 2 (Eg Codons 12 And 13) And Exon 3 (Eg Codon 61)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81312	Pabpn1 (Poly[A] Binding Protein Nuclear 1) (Eg Oculopharyngeal Muscular Dystrophy) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81313	Pca3/Klk3 (Prostate Cancer Antigen 3 [Non-Protein Coding]/Kallikrein-Related Peptidase 3 [Prostate Specific Antigen]) Ratio (Eg Prostate Cancer)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81314	Pdgfra (Platelet-Derived Growth Factor Receptor Alpha Polypeptide) (Eg Gastrointestinal Stromal Tumor [Gist]) Gene Analysis Targeted Sequence Analysis (Eg Exons 12 18)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81315	Pml/Raralpha (T(15;17)) (Promyelocytic Leukemia/Retinoic Acid Receptor Alpha) (Eg Promyelocytic Leukemia) Translocation Analysis; Common Breakpoints (Eg Intron 3 And Intron 6) Qualitative Or Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81316	Pml/Raralpha (T(15;17)) (Promyelocytic Leukemia/Retinoic Acid Receptor Alpha) (Eg Promyelocytic Leukemia) Translocation Analysis; Single Breakpoint (Eg Intron 3 Intron 6 Or Exon 6) Qualitative Or Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81317	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81318	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81319	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81320	Plcg2 (Phospholipase C Gamma 2) (Eg Chronic Lymphocytic Leukemia) Gene Analysis Common Variants (Eg R665W S707F L845F)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81321	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81322	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81323	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Duplication/Deletion Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81324	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie-Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Duplication/Deletion Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81325	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie-Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81326	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie-Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81327	Sept9 (Septin9) (Eg Colorectal Cancer) Promoter Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81328	Slco1B1 (Solute Carrier Organic Anion Transporter Family Member 1B1) (Eg Adverse Drug Reaction) Gene Analysis Common Variant(S) (Eg *5)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81330	Smpd1 (Sphingomyelin Phosphodiesterase 1 Acid Lysosomal) (Eg Niemann-Pick Disease Type A) Gene Analysis Common Variants (Eg R496L L302P Fsp330)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81331	Snrpn/Ube3A (Small Nuclear Ribonucleoprotein Polypeptide N And Ubiquitin Protein Ligase E3A) (Eg Prader-Willi Syndrome And/Or Angelman Syndrome) Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81332	Serpina1 (Serpin Peptidase Inhibitor Clade A Alpha-1 Antiproteinase Antitrypsin Member 1) (Eg Alpha-1-Antitrypsin Deficiency) Gene Analysis Common Variants (Eg *S And *Z)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81333	Tgfbi (Transforming Growth Factor Beta-Induced) (Eg Corneal Dystrophy) Gene Analysis Common Variants (Eg R124H R124C R124L R555W R555Q)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81334	Runx1 (Runt Related Transcription Factor 1) (Eg Acute Myeloid Leukemia Familial Platelet Disorder With Associated Myeloid Malignancy) Gene Analysis Targeted Sequence Analysis (Eg Exons 3-8)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81335	Tpmt (Thiopurine S-Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81336	Smn1 (Survival Of Motor Neuron 1 Telomeric) (Eg Spinal Muscular Atrophy) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81337	Smn1 (Survival Of Motor Neuron 1 Telomeric) (Eg Spinal Muscular Atrophy) Gene Analysis; Known Familial Sequence Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81338	Mpl (Mpl Proto-Oncogene Thrombopoietin Receptor) (Eg Myeloproliferative Disorder) Gene Analysis; Common Variants (Eg W515A W515K W515L W515R)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81339	Mpl (Mpl Proto-Oncogene Thrombopoietin Receptor) (Eg Myeloproliferative Disorder) Gene Analysis; Sequence Analysis Exon 10	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81340	Trb@ (T Cell Antigen Receptor Beta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Using Amplification Methodology (Eg Polymerase Chain Reaction)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81341	Trb@ (T Cell Antigen Receptor Beta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Using Direct Probe Methodology (Eg Southern Blot)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81342	Trg@ (T Cell Antigen Receptor Gamma) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis Evaluation To Detect Abnormal Clonal Population(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81343	Ppp2R2B (Protein Phosphatase 2 Regulatory Subunit Bbeta) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81344	Tbp (Tata Box Binding Protein) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81345	Tert (Telomerase Reverse Transcriptase) (Eg Thyroid Carcinoma Glioblastoma Multiforme) Gene Analysis Targeted Sequence Analysis (Eg Promoter Region)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81346	Tyms (Thymidylate Synthetase) (Eg 5-Fluorouracil/5-Fu Drug Metabolism) Gene Analysis Common Variant(S) (Eg Tandem Repeat Variant)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81347	Sf3B1 (Splicing Factor [3B] Subunit B1) (Eg Myelodysplastic Syndrome/Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg A672T E622D L833F R625C R625L)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81348	Srsf2 (Serine And Arginine-Rich Splicing Factor 2) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg P95H P95L)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81349	Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number And Loss-Of-Heterozygosity Variants Low-Pass Sequencing Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81350	Ugt1A1 (Udp Glucuronosyltransferase 1 Family Polypeptide A1) (Eg Drug Metabolism Hereditary Unconjugated Hyperbilirubinemia [Gilbert Syndrome]) Gene Analysis Common Variants (Eg *28 *36 *37)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81351	Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81352	Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene Analysis; Targeted Sequence Analysis (Eg 4 Oncology)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81353	Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81355	Vkorc1 (Vitamin K Epoxide Reductase Complex Subunit 1) (Eg Warfarin Metabolism) Gene Analysis Common Variant(S) (Eg -1639G>A C.173+1000C>T)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81357	U2Af1 (U2 Small Nuclear Rna Auxiliary Factor 1) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg S34F S34Y Q157R Q157P)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81360	Zrsr2 (Zinc Finger Ccch-Type Rna Binding Motif And Serine/Arginine-Rich 2) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variant(S) (Eg E65Fs E122Fs R448Fs)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81361	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Common Variant(S) (Eg Hbs Hbc Hbe)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81362	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Known Familial Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81363	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Duplication/Deletion Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81364	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81400	Molecular Pathology Procedure Level 1 (Eg Identification Of Single Germline Variant [Eg Snp] By Techniques Such As Restriction Enzyme Digestion Or Melt Curve Analysis) Acadm (Acyl-Coa Dehydrogenase C-4 To C-12 Straight Chain Mcad) (Eg Medium Chain Acyl Dehydrogenase Deficiency) K304E Variant Ace (Angiotensin Converting Enzyme) (Eg Hereditary Blood Pressure Regulation) Insertion/Deletion Variant Agtr1 (Angiotensin Ii Receptor Type 1) (Eg Essential Hypertension) 1166A>C Variant Bckdha (Branched Chain Keto Acid Dehydrogenase E1 Alpha Polypeptide) (Eg Maple Syrup Urine Disease Type 1A) Y438N Variant Ccr5 (Chemokine C-C Motif Receptor 5) (Eg Hiv Resistance) 32-Bp Deletion Mutation/794 825Del32 Deletion Clrn1 (Clarin 1) (Eg Usher Syndrome Type 3) N48K Variant F2 (Coagulation Factor 2) (Eg Hereditary Hypercoagulability) 1199G>A Variant F5 (Coagulation Factor V) (Eg Hereditary Hypercoagulability) Hr2 Variant F7 (Coagulation Factor Vii [Serum Prothrombin Conversion Accelerator]) (Eg Hereditary Hypercoagulability) R353Q Variant F13B (Coagulation Factor Xiii B Polypeptide) (Eg Hereditary Hypercoagulability) V34L Variant Fgb (Fibrinogen Beta Chain) (Eg Hereditary Ischemic Heart Disease) -455G>A Variant Fgfr1 (Fibroblast Growth Factor Receptor 1) (Eg Pfeiffer Syndrome Type 1 Craniosynostosis) P252R Variant Fgfr3	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81401	Molecular Pathology Procedure Level 2 (Eg 2-10 Snps 1 Methylated Variant Or 1 Somatic Variant [Typically Using Nonsequencing Target Variant Analysis] Or Detection Of A Dynamic Mutation Disorder/Triplet Repeat) Abcc8 (Atp-Binding Cassette Sub-Family C [Cftr/Mrp] Member 8) (Eg Familial Hyperinsulinism) Common Variants (Eg C.3898-9G>A [C.3992-9G>A] F1388Del) Abl1 (Abl Proto-Oncogene 1 Non-Receptor Tyrosine Kinase) (Eg Acquired Imatinib Resistance) T315I Variant Acadm (Acyl-Coa Dehydrogenase C-4 To C-12 Straight Chain Mcad) (Eg Medium Chain Acyl Dehydrogenase Deficiency) Commons Variants (Eg K304E Y42H) Adrb2 (Adrenergic Beta-2 Receptor Surface) (Eg Drug Metabolism) Common Variants (Eg G16R Q27E) Apob (Apolipoprotein B) (Eg Familial Hypercholesterolemia Type B) Common Variants (Eg R3500Q R3500W) Apoe (Apolipoprotein E) (Eg Hyperlipoproteinemia Type Iii Cardiovascular Disease Alzheimer Disease) Common Variants (Eg *2 *3 *4) Cbfb/Myh11 (Inv(16)) (Eg Acute Myeloid Leukemia) Qualitative And Quantitative If Performed Cbs (Cystathionine-Beta-Synthase) (Eg Homocystinuria Cystathionine Beta-Synthase Deficiency) Common Variants (Eg I278T G307S) Cfh/Arms2 (Complement Factor H/Age-Related Maculopathy Susceptibility 2) (Eg Macular Degeneration) Common Variants (Eg	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81402	Molecular Pathology Procedure Level 3 (Eg >10 Snps 2-10 Methylated Variants Or 2-10 Somatic Variants [Typically Using Non-Sequencing Target Variant Analysis] Immunoglobulin And T-Cell Receptor Gene Rearrangements Duplication/Deletion Variants Of 1 Exon Loss Of Heterozygosity [Loh] Uniparental Disomy [Upd]) Chromosome 1P-/19Q- (Eg Glial Tumors) Deletion Analysis Chromosome 18Q- (Eg D18S55 D18S58 D18S61 D18S64 And D18S69) (Eg Colon Cancer) Allelic Imbalance Assessment (Ie Loss Of Heterozygosity) Col1A1/Pdgfb (T(17;22)) (Eg Dermatofibrosarcoma Protuberans) Translocation Analysis Multiple Breakpoints Qualitative And Quantitative If Performed Cyp21A2 (Cytochrome P450 Family 21 Subfamily A Polypeptide 2) (Eg Congenital Adrenal Hyperplasia 21-Hydroxylase Deficiency) Common Variants (Eg Ivs2-13G P30L I172N Exon 6 Mutation Cluster [I235N V236E M238K] V281L L307Ffsx6 Q318X R356W P453S G110Vfsx21 30-Kb Deletion Variant) Esr1/Pgr (Receptor 1/Progesterone Receptor) Ratio (Eg Breast Cancer) Mefv (Mediterranean Fever) (Eg Familial Mediterranean Fever) Common Variants (Eg E148Q P369S F479L M680I I692Del M694V M694I K695R V726A A744S R761H) Trd@ (T Cell Antigen Receptor Delta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis Evaluation To Detect	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81403	Molecular Pathology Procedure Level 4 (Eg Analysis Of Single Exon By Dna Sequence Analysis Analysis Of >10 Amplicons Using Multiplex Pcr In 2 Or More Independent Reactions Mutation Scanning Or Duplication/Deletion Variants Of 2-5 Exons) Ang (Angiogenin Ribonuclease Rnase A Family 5) (Eg Amyotrophic Lateral Sclerosis) Full Gene Sequence Arx (Aristaless Related Homeobox) (Eg X-Linked Lissencephaly With Ambiguous Genitalia X-Linked Intellectual Disability) Duplication/Deletion Analysis Cel (Carboxyl Ester Lipase [Bile Salt-Stimulated Lipase]) (Eg Maturity-Onset Diabetes Of The Young [Mody]) Targeted Sequence Analysis Of Exon 11 (Eg C.1785Delc C.1686Delt) Ctnnb1 (Catenin [Cadherin-Associated Protein] Beta 1 88Kda) (Eg Desmoid Tumors) Targeted Sequence Analysis (Eg Exon 3) Daz/Sry (Deleted In Azoospermia And Sex Determining Region Y) (Eg Male Infertility) Common Deletions (Eg Azfa Azfb Azfc Azfd) Dnmt3A (Dna [Cytosine-5-]-Methyltransferase 3 Alpha) (Eg Acute Myeloid Leukemia) Targeted Sequence Analysis (Eg Exon 23) Epcam (Epithelial Cell Adhesion Molecule) (Eg Lynch Syndrome) Duplication/Deletion Analysis F8 (Coagulation Factor Viii) (Eg Hemophilia A) Inversion Analysis Intron 1 And Intron 22A F12 (Coagulation Factor Xii [Hageman Factor]) (Eg Angioedema Hereditary Type Iii; Factor Xii	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81404	Molecular Pathology Procedure Level 5 (Eg Analysis Of 2-5 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 6-10 Exons Or Characterization Of A Dynamic Mutation Disorder/Triplet Repeat By Southern Blot Analysis) Acads (Acyl-Coa Dehydrogenase C-2 To C-3 Short Chain) (Eg Short Chain Acyl-Coa Dehydrogenase Deficiency) Targeted Sequence Analysis (Eg Exons 5 And 6) Aqp2 (Aquaporin 2 [Collecting Duct]) (Eg Nephrogenic Diabetes Insipidus) Full Gene Sequence Arx (Aristaless Related Homeobox) (Eg X-Linked Lissencephaly With Ambiguous Genitalia X-Linked Intellectual Disability) Full Gene Sequence Avpr2 (Arginine Vasopressin Receptor 2) (Eg Nephrogenic Diabetes Insipidus) Full Gene Sequence Bbs10 (Bardet-Biedl Syndrome 10) (Eg Bardet-Biedl Syndrome) Full Gene Sequence Btd (Biotinidase) (Eg Biotinidase Deficiency) Full Gene Sequence C10Orf2 (Chromosome 10 Open Reading Frame 2) (Eg Mitochondrial Dna Depletion Syndrome) Full Gene Sequence Cav3 (Caveolin 3) (Eg Cav3-Related Distal Myopathy Limb-Girdle Muscular Dystrophy Type 1C) Full Gene Sequence Cd40Lg (Cd40 Ligand) (Eg X-Linked Hyper Igm Syndrome) Full Gene Sequence Cdkn2A (Cyclin-Dependent Kinase Inhibitor 2A) (Eg Cdkn2A-Related Cutaneous Malignant Melanoma Familial Atypical Mole-[illegible]	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81405	Molecular Pathology Procedure Level 6 (Eg Analysis Of 6-10 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 11-25 Exons Regionally Targeted Cytogenomic Array Analysis) Abcd1 (Atp-Binding Cassette Sub-Family D [Ald] Member 1) (Eg Adrenoleukodystrophy) Full Gene Sequence Acads (Acyl-Coa Dehydrogenase C-2 To C-3 Short Chain) (Eg Short Chain Acyl-Coa Dehydrogenase Deficiency) Full Gene Sequence Acta2 (Actin Alpha 2 Smooth Muscle Aorta) (Eg Thoracic Aortic Aneurysms And Aortic Dissections) Full Gene Sequence Actc1 (Actin Alpha Cardiac Muscle 1) (Eg Familial Hypertrophic Cardiomyopathy) Full Gene Sequence Ankrd1 (Ankyrin Repeat Domain 1) (Eg Dilated Cardiomyopathy) Full Gene Sequence Aptx (Aprataxin) (Eg Ataxia With Oculomotor Apraxia 1) Full Gene Sequence Arsa (Arylsulfatase A) (Eg Arylsulfatase A Deficiency) Full Gene Sequence Bckdha (Branched Chain Keto Acid Dehydrogenase E1 Alpha Polypeptide) (Eg Maple Syrup Urine Disease Type 1A) Full Gene Sequence Bcs1L (Bcs1-Like [S. Cerevisiae]) (Eg Leigh Syndrome Mitochondrial Complex Iii Deficiency Gracile Syndrome) Full Gene Sequence Bmpr2 (Bone Morphogenetic Protein Receptor Type Ii [Serine/Threonine Kinase]) (Eg Heritable Pulmonary Arterial Hypertension)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81406	Molecular Pathology Procedure Level 7 (Eg Analysis Of 11-25 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 26-50 Exons) Acadvl (Acyl-Coa Dehydrogenase Very Long Chain) (Eg Very Long Chain Acyl-Coenzyme A Dehydrogenase Deficiency) Full Gene Sequence Actn4 (Actinin Alpha 4) (Eg Focal Segmental Glomerulosclerosis) Full Gene Sequence Afg3L2 (Afg3 Atpase Family Gene 3-Like 2 [S. Cerevisiae]) (Eg Spinocerebellar Ataxia) Full Gene Sequence Aire (Autoimmune Regulator) (Eg Autoimmune Polyendocrinopathy Syndrome Type 1) Full Gene Sequence Aldh7A1 (Aldehyde Dehydrogenase 7 Family Member A1) (Eg Pyridoxine-Dependent Epilepsy) Full Gene Sequence Ano5 (Anoctamin 5) (Eg Limb-Girdle Muscular Dystrophy) Full Gene Sequence Anos1 (Anosmin-1) (Eg Kallmann Syndrome 1) Full Gene Sequence App (Amyloid Beta [A4] Precursor Protein) (Eg Alzheimer Disease) Full Gene Sequence Ass1 (Argininosuccinate Synthase 1) (Eg Citrullinemia Type I) Full Gene Sequence Atl1 (Atlastin Gtpase 1) (Eg Spastic Paraplegia) Full Gene Sequence Atp1A2 (Atpase Na+/K+ Transporting Alpha 2 Polypeptide) (Eg Familial Hemiplegic Migraine) Full Gene Sequence Atp7B (Atpase Cu++ Transporting Beta Polypeptide) (Eg Wilson Disease) Full Gene Sequence Bbs1 (Bardet-Biedl Syndrome 1) (Eg Bardet-Biedl	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81407	Molecular Pathology Procedure Level 8 (Eg Analysis Of 26-50 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of >50 Exons Sequence Analysis Of Multiple Genes On One Platform) Abcc8 (Atp-Binding Cassette Sub-Family C [Cftr/Mrp] Member 8) (Eg Familial Hyperinsulinism) Full Gene Sequence Agl (Amylo-Alpha-1 6-Glucosidase 4-Alpha-Glucanotransferase) (Eg Glycogen Storage Disease Type Iii) Full Gene Sequence Ahi1 (Abelson Helper Integration Site 1) (Eg Joubert Syndrome) Full Gene Sequence Apob (Apolipoprotein B) (Eg Familial Hypercholesterolemia Type B) Full Gene Sequence Aspm (Asp [Abnormal Spindle] Homolog Microcephaly Associated [Drosophila]) (Eg Primary Microcephaly) Full Gene Sequence Chd7 (Chromodomain Helicase Dna Binding Protein 7) (Eg Charge Syndrome) Full Gene Sequence Col4A4 (Collagen Type Iv Alpha 4) (Eg Alport Syndrome) Full Gene Sequence Col4A5 (Collagen Type Iv Alpha 5) (Eg Alport Syndrome) Duplication/Deletion Analysis Col6A1 (Collagen Type Vi Alpha 1) (Eg Collagen Type Vi-Related Disorders) Full Gene Sequence Col6A2 (Collagen Type Vi Alpha 2) (Eg Collagen Type Vi-Related Disorders) Full Gene Sequence Col6A3 (Collagen Type Vi Alpha 3) (Eg Collagen Type Vi-Related Disorders) Full Gene Sequence Crebbp (Creb	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

81408	Molecular Pathology Procedure Level 9 (Eg Analysis Of >50 Exons In A Single Gene By Dna Sequence Analysis) Abca4 (Atp-Binding Cassette Sub-Family A [Abc1] Member 4) (Eg Stargardt Disease Age-Related Macular Degeneration) Full Gene Sequence Atm (Ataxia Telangiectasia Mutated) (Eg Ataxia Telangiectasia) Full Gene Sequence Cdh23 (Cadherin-Related 23) (Eg Usher Syndrome Type 1) Full Gene Sequence Cep290 (Centrosomal Protein 290Kda) (Eg Joubert Syndrome) Full Gene Sequence Col1A1 (Collagen Type I Alpha 1) (Eg Osteogenesis Imperfecta Type I) Full Gene Sequence Col1A2 (Collagen Type I Alpha 2) (Eg Osteogenesis Imperfecta Type I) Full Gene Sequence Col4A1 (Collagen Type Iv Alpha 1) (Eg Brain Small-Vessel Disease With Hemorrhage) Full Gene Sequence Col4A3 (Collagen Type Iv Alpha 3 [Goodpasture Antigen]) (Eg Alport Syndrome) Full Gene Sequence Col4A5 (Collagen Type Iv Alpha 5) (Eg Alport Syndrome) Full Gene Sequence Dmd (Dystrophin) (Eg Duchenne/Becker Muscular Dystrophy) Full Gene Sequence Dysf (Dysferlin Limb Girdle Muscular Dystrophy 2B [Autosomal Recessive]) (Eg Limb-Girdle Muscular Dystrophy) Full Gene Sequence Fbn1 (Fibrillin 1) (Eg Marfan Syndrome) Full Gene Sequence Itpr1 (Inositol 1 4 5-Trisphosphate Receptor Type 1) (Eg Spinocerebellar Ataxia) Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81410	Aortic Dysfunction Or Dilation (Eg Marfan Syndrome Loeys Dietz Syndrome Ehler Danlos Syndrome Type Iv Arterial Tortuosity Syndrome); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 9 Genes Including Fbn1 Tgfbr1 Tgfbr2 Col3A1 Myh11 Acta2 Slc2A10 Smad3 And Mylk	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81411	Aortic Dysfunction Or Dilation (Eg Marfan Syndrome Loeys Dietz Syndrome Ehler Danlos Syndrome Type Iv Arterial Tortuosity Syndrome); Duplication/Deletion Analysis Panel Must Include Analyses For Tgfbr1 Tgfbr2 Myh11 And Col3A1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81412	Ashkenazi Jewish Associated Disorders (Eg Bloom Syndrome Canavan Disease Cystic Fibrosis Familial Dysautonomia Fanconi Anemia Group C Gaucher Disease Tay-Sachs Disease) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 9 Genes Including Aspa Blm Cftr Fancc Gba Hexa Ikbkap Mcoln1 And Smpd1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81413	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Including Ank2 Casq2 Cav3 Kcne1 Kcne2 Kcnh2 Kcnj2 Kcnq1 Ryr2 And Scn5A	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81414	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia); Duplication/Deletion Gene Analysis Panel Must Include Analysis Of At Least 2 Genes Including Kcnh2 And Kcnq1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81415	Exome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81416	Exome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis Each Comparator Exome (Eg Parents Siblings) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81417	Exome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Re-Evaluation Of Previously Obtained Exome Sequence (Eg Updated Knowledge Or Unrelated Condition/Syndrome)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81418	Drug Metabolism (Eg Pharmacogenomics) Genomic Sequence Analysis Panel Must Include Testing Of At Least 6 Genes Including Cyp2C19 Cyp2D6 And Cyp2D6 Duplication/Deletion Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81419	Epilepsy Genomic Sequence Analysis Panel Must Include Analyses For Aldh7A1 Cacna1A Cdkl5 Chd2 Gabrg2 Grin2A Kcnq2 Mecp2 Pcdh19 Polg Prrt2 Scn1A Scn1B Scn2A Scn8A Slc2A1 Slc9A6 Stxbp1 Syngap1 Tcf4 Tpp1 Tsc1 Tsc2 And Zeb2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81422	Fetal Chromosomal Microdeletion(S) Genomic Sequence Analysis (Eg Digeorge Syndrome Cri-Du-Chat Syndrome) Circulating Cell-Free Fetal Dna In Maternal Blood	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81425	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81426	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis Each Comparator Genome (Eg Parents Siblings) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81427	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Re-Evaluation Of Previously Obtained Genome Sequence (Eg Updated Knowledge Or Unrelated Condition/Syndrome)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81430	Hearing Loss (Eg Nonsyndromic Hearing Loss Usher Syndrome Pendred Syndrome); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 60 Genes Including Cdh23 Clrn1 Gjb2 Gpr98 Mtrnr1 Myo7A Myo15A Pcdh15 Otof Slc26A4 Tmc1 Tmprss3 Ush1C Ush1G Ush2A And Wfs1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81431	Hearing Loss (Eg Nonsyndromic Hearing Loss Usher Syndrome Pendred Syndrome); Duplication/Deletion Analysis Panel Must Include Copy Number Analyses For Strc And Dfnb1 Deletions In Gjb2 And Gjb6 Genes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81432	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Always Including Brca1 Brca2 Cdh1 Mlh1 Msh2 Msh6 Palb2 Pten Stk11 And Tp53	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81433	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer); Duplication/Deletion Analysis Panel Must Include Analyses For Brca1 Brca2 Mlh1 Msh2 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81434	Hereditary Retinal Disorders (Eg Retinitis Pigmentosa Leber Congenital Amaurosis Cone-Rod Dystrophy) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 15 Genes Including Abca4 Cnga1 Crb1 Eys Pde6A Pde6B Prpf31 Prph2 Rdh12 Rho Rp1 Rp2 Rpe65 Rpgr And Ush2A	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81435	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Including Apc Bmpr1A Cdh1 Mlh1 Msh2 Msh6 Mutyh Pten Smad4 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81436	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis); Duplication/Deletion Analysis Panel Must Include Analysis Of At Least 5 Genes Including Mlh1 Msh2 Epcam Smad4 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81437	Hereditary Neuroendocrine Tumor Disorders (Eg Medullary Thyroid Carcinoma Parathyroid Carcinoma Malignant Pheochromocytoma Or Paraganglioma); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 6 Genes Including Max Sdhb Sdhc Sdhd Tmem127 And Vhl	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81438	Hereditary Neuroendocrine Tumor Disorders (Eg Medullary Thyroid Carcinoma Parathyroid Carcinoma Malignant Pheochromocytoma Or Paraganglioma); Duplication/Deletion Analysis Panel Must Include Analyses For Sdhb Sdhc Sdhd And Vhl	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81439	Hereditary Cardiomyopathy (Eg Hypertrophic Cardiomyopathy Dilated Cardiomyopathy Arrhythmogenic Right Ventricular Cardiomyopathy) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 5 Cardiomyopathy-Related Genes (Eg Dsg2 Mybpc3 Myh7 Pkp2 Ttn)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81440	Nuclear Encoded Mitochondrial Genes (Eg Neurologic Or Myopathic Phenotypes) Genomic Sequence Panel Must Include Analysis Of At Least 100 Genes Including Bcs1L C10Orf2 Coq2 Cox10 Dguok Mpv17 Opa1 Pdss2 Polg Polg2 Rrm2B Sco1 Sco2 Slc25A4 Sucla2 Suclg1 Taz Tk2 And Tymp	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81441	Inherited Bone Marrow Failure Syndromes (Ibmfs) (Eg Fanconi Anemia Dyskeratosis Congenita Diamond-Blackfan Anemia Shwachman-Diamond Syndrome Gata2 Deficiency Syndrome Congenital Amegakaryocytic Thrombocytopenia) Sequence Analysis Panel Must Include Sequencing Of At Least 30 Genes Including Brca2 Brip1 Dkc1 Fanca Fancb Fancc Fancd2 Fance Fancf Fancg Fanci Fancl Gata1 Gata2 Mpl Nhp2 Nop10 Palb2 Rad51C Rpl11 Rpl35A Rpl5 Rps10 Rps19 Rps24 Rps26 Rps7 Sbds Tert And Tinf2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81442	Noonan Spectrum Disorders (Eg Noonan Syndrome Cardio-Facio-Cutaneous Syndrome Costello Syndrome Leopard Syndrome Noonan-Like Syndrome) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 12 Genes Including Braf Cbl Hras Kras Map2K1 Map2K2 Nras Ptpn11 Raf1 Rit1 Shoc2 And Sos1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81443	Genetic Testing For Severe Inherited Conditions (Eg Cystic Fibrosis Ashkenazi Jewish-Associated Disorders [Eg Bloom Syndrome Canavan Disease Fanconi Anemia Type C Mucolipidosis Type Vi Gaucher Disease Tay-Sachs Disease] Beta Hemoglobinopathies Phenylketonuria Galactosemia) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 15 Genes (Eg Acadm Arsa Aspa Atp7B Bckdha Bckdhb Blm Cftr Dhcr7 Fancc G6Pc Gaa Galt Gba Gbe1 Hbb Hexa Ikbkap Mcoln1 Pah)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81445	Solid Organ Neoplasm Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81448	Hereditary Peripheral Neuropathies (Eg Charcot-Marie-Tooth Spastic Paraplegia) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 5 Peripheral Neuropathy-Related Genes (Eg Bscl2 Gjb1 Mfn2 Mpz Reep1 Spast Spg11 Sptlc1)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81449	Solid Organ Neoplasm Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81450	Hematolymphoid Neoplasm Or Disorder Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81451	Hematolymphoid Neoplasm Or Disorder Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81455	Solid Organ Or Hematolymphoid Neoplasm Or Disorder 51 Or Greater Genes Genomic Sequence Analysis Panel Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81456	Solid Organ Or Hematolymphoid Neoplasm Or Disorder 51 Or Greater Genes Genomic Sequence Analysis Panel Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81460	Whole Mitochondrial Genome (Eg Leigh Syndrome Mitochondrial Encephalomyopathy Lactic Acidosis And Stroke-Like Episodes [Melas] Myoclonic Epilepsy With Ragged-Red Fibers [Merff] Neuropathy Ataxia And Retinitis Pigmentosa [Narp] Leber Hereditary Optic Neuropathy [Lhon]) Genomic Sequence Must Include Sequence Analysis Of Entire Mitochondrial Genome With Heteroplasmy Detection	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81465	Whole Mitochondrial Genome Large Deletion Analysis Panel (Eg Kearns-Sayre Syndrome Chronic Progressive External Ophthalmoplegia) Including Heteroplasmy Detection If Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81470	X-Linked Intellectual Disability (Xlid) (Eg Syndromic And Non-Syndromic Xlid); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 60 Genes Including Arx Atrx Cdkl5 Fgd1 Fmr1 Huwe1 Il1Rapl Kdm5C L1Cam Mecp2 Med12 Mid1 Ocrl Rps6Ka3 And Slc16A2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81471	X-Linked Intellectual Disability (Xlid) (Eg Syndromic And Non-Syndromic Xlid); Duplication/Deletion Gene Analysis Must Include Analysis Of At Least 60 Genes Including Arx Atrx Cdkl5 Fgd1 Fmr1 Huwe1 Il1Rapl Kdm5C L1Cam Mecp2 Med12 Mid1 Ocrl Rps6Ka3 And Slc16A2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81479	Unlisted Molecular Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
81493	Coronary Artery Disease Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 23 Genes Utilizing Whole Peripheral Blood Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81504	Oncology (Tissue Of Origin) Microarray Gene Expression Profiling Of > 2000 Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Tissue Similarity Scores	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81518	Oncology (Breast) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 11 Genes (7 Content And 4 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithms Reported As Percentage Risk For Metastatic Recurrence And Likelihood Of Benefit From Extended Endocrine Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81519	Oncology (Breast) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 21 Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81520	Oncology (Breast) Mrna Gene Expression Profiling By Hybrid Capture Of 58 Genes (50 Content And 8 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81521	Oncology (Breast) Mrna Microarray Gene Expression Profiling Of 70 Content Genes And 465 Housekeeping Genes Utilizing Fresh Frozen Or Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Index Related To Risk Of Distant Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81522	Oncology (Breast) Mrna Gene Expression Profiling By Rt-Pcr Of 12 Genes (8 Content And 4 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81523	Oncology (Breast) Mrna Next-Generation Sequencing Gene Expression Profiling Of 70 Content Genes And 31 Housekeeping Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Index Related To Risk To Distant Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81525	Oncology (Colon) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 12 Genes (7 Content And 5 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Recurrence Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81529	Oncology (Cutaneous Melanoma) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 31 Genes (28 Content And 3 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Risk Including Likelihood Of Sentinel Lymph Node Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81540	Oncology (Tumor Of Unknown Origin) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 92 Genes (87 Content And 5 Housekeeping) To Classify Tumor Into Main Cancer Type And Subtype Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Probability Of A Predicted Main Cancer Type And Subtype	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81541	Oncology (Prostate) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 46 Genes (31 Content And 15 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Disease-Specific Mortality Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81542	Oncology (Prostate) Mrna Microarray Gene Expression Profiling Of 22 Content Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Metastasis Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81546	Oncology (Thyroid) Mrna Gene Expression Analysis Of 10 196 Genes Utilizing Fine Needle Aspirate Algorithm Reported As A Categorical Result (Eg Benign Or Suspicious)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81551	Oncology (Prostate) Promoter Methylation Profiling By Real-Time Pcr Of 3 Genes (Gstp1 Apc Rassf1) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Likelihood Of Prostate Cancer Detection On Repeat Biopsy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
81552	Oncology (Uveal Melanoma) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 15 Genes (12 Content And 3 Housekeeping) Utilizing Fine Needle Aspirate Or Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Risk Of Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

81554	Pulmonary Disease (Idiopathic Pulmonary Fibrosis [Ipf]) Mrna Gene Expression Analysis Of 190 Genes Utilizing Transbronchial Biopsies Diagnostic Algorithm Reported As Categorical Result (Eg Positive Or Negative For High Probability Of Usual Interstitial Pneumonia [Uip])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–
81595	Cardiology (Heart Transplant) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of 20 Genes (11 Content And 9 Housekeeping) Utilizing Subfraction Of Peripheral Blood Algorithm Reported As A Rejection Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–
82523	Collagen cross links, any method	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
83006	Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
83695	Lipoprotein (a)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

83722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
83937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
83987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
86352	Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
86911	Blood typing, for paternity testing, per individual; each additional antigen system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
86950	Leukocyte transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999

87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
88000	Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88012	Necropsy (autopsy), gross examination only; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88025	Necropsy (autopsy), gross and microscopic; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88027	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88028	Necropsy (autopsy), gross and microscopic; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88040	Necropsy (autopsy); forensic examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88045	Necropsy (autopsy); coroner's call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88099	Unlisted necropsy (autopsy) procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
89258	Cryopreservation; embryo(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/24/2024	12/31/2999
89258	Cryopreservation; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	4/23/2024
89259	Cryopreservation; sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
89335	Cryopreservation, reproductive tissue, testicular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
89337	Cryopreservation, mature oocyte(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
89342	Storage (per year); embryo(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
89343	Storage (per year); sperm/semen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
89344	Storage (per year); reproductive tissue, testicular/ovarian	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
89346	Storage (per year); oocyte(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/24/2024	12/31/2999
89346	Storage (per year); oocyte(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	4/23/2024
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
90378	Respiratory Syncytial Virus Monoclonal Antibody Recombinant For Intramuscular Use 50 Mg Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–

90584	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2022	12/31/2999
90689	Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	5/31/2024
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

90901	Biofeedback training by any modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2006	12/31/2999
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2006	12/31/2999
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2006	12/31/2999
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2020	12/31/2999
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
92015	Determination of refractive state	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92065	Orthoptic training; performed by a physician or other qualified health care professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2013	12/31/2999
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
92340	Fitting of spectacles, except for aphakia; monofocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92341	Fitting of spectacles, except for aphakia; bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92354	Fitting of spectacle mounted low vision aid; single element system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92370	Repair and refitting spectacles; except for aphakia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92512	Nasal function studies (eg, rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
92546	Sinusoidal vertical axis rotational testing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2008	12/31/2999
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
92978	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
92979	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93153	Interrogation without programming of implanted phrenic nerve stimulator system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
93153	Interrogation without programming of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
93740	Temperature gradient studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
94016	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
94452	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
94453	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
95065	Direct nasal mucous membrane test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999

95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999

95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999

95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	9/30/2024

95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
95919	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
96000	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96001	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999

96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2009	12/31/2999
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
96922	Excimer laser treatment for psoriasis; over 500 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2007	12/31/2999
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999

96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
97039	Unlisted Modality (Specify Type And Time If Constant Attendance)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
97139	Unlisted Therapeutic Procedure (Specify)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there is a documented change; and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	2/29/2024
99024	Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99075	Medical testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99360	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
0001U	Red Blood Cell Antigen Typing Dna Human Erythrocyte Antigen Gene Analysis Of 35 Antigens From 11 Blood Groups Utilizing Whole Blood Common Rbc Alleles Reported	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0004M	Scoliosis Dna Analysis Of 53 Single Nucleotide Polymorphisms (Snps) Using Saliva Prognostic Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0005U	Oncology (Prostate) Gene Expression Profile By Real-Time Rt-Pcr Of 3 Genes (Erg Pca3 And Spdef) Urine Algorithm Reported As Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0006M	Oncology (Hepatic) Mrna Expression Levels Of 161 Genes Utilizing Fresh Hepatocellular Carcinoma Tumor Tissue With Alpha-Fetoprotein Level Algorithm Reported As A Risk Classifier	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0007M	Oncology (Gastrointestinal Neuroendocrine Tumors) Real-Time Pcr Expression Analysis Of 51 Genes Utilizing Whole Peripheral Blood Algorithm Reported As A Nomogram Of Tumor Disease Index	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0011M	Oncology Prostate Cancer Mrna Expression Assay Of 12 Genes (10 Content And 2 Housekeeping) Rt-Pcr Test Utilizing Blood Plasma And Urine Algorithms To Predict High-Grade Prostate Cancer Risk	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0012M	Oncology (Urothelial) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of Five Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Reported As A Risk Score For Having Urothelial Carcinoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0013M	Oncology (Urothelial) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of Five Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Reported As A Risk Score For Having Recurrent Urothelial Carcinoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0016M	Oncology (Bladder) Mrna Microarray Gene Expression Profiling Of 219 Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Molecular Subtype (Luminal Luminal Infiltrated Basal Basal Claudin-Low Neuroendocrine-Like)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0016U	Oncology (Hematolymphoid Neoplasia) Rna Bcr/Abl1 Major And Minor Breakpoint Fusion Transcripts Quantitative Pcr Amplification Blood Or Bone Marrow Report Of Fusion Not Detected Or Detected With Quantitation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0017M	Oncology (Diffuse Large B-Cell Lymphoma [Dlbcl]) Mrna Gene Expression Profiling By Fluorescent Probe Hybridization Of 20 Genes Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Cell Of Origin	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0017U	Oncology (Hematolymphoid Neoplasia) Jak2 Mutation Dna Pcr Amplification Of Exons 12-14 And Sequence Analysis Blood Or Bone Marrow Report Of Jak2 Mutation Not Detected Or Detected	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0018U	Oncology (Thyroid) Microrna Profiling By Rt-Pcr Of 10 Microrna Sequences Utilizing Fine Needle Aspirate Algorithm Reported As A Positive Or Negative Result For Moderate To High Risk Of Malignancy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0019U	Oncology Rna Gene Expression By Whole Transcriptome Sequencing Formalin-Fixed Paraffin Embedded Tissue Or Fresh Frozen Tissue Predictive Algorithm Reported As Potential Targets For Therapeutic Agents	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0020M	Oncology (central nervous system), analysis of 30000 DNA methylation loci by methylation array, utilizing DNA extracted from tumor tissue, diagnostic algorithm reported as probability of matching a reference tumor subclass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0022U	Targeted Genomic Sequence Analysis Panel Nonsmall Cell Lung Neoplasia Dna And Rna Analysis 23 Genes Interrogation For Sequence Variants And Rearrangements Reported As Presence/-Or Absence Of Variants And Associated Therapy(Ies) To Consider	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0023U	Oncology (Acute Myelogenous Leukemia) Dna Genotyping Of Internal Tandem Duplication P.D835 P.I836 Using Mononuclear Cells Reported As Detection Or Non-Detection Of Flt3 Mutation And Indication For Or Against The Use Of Midostaurin	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0026U	Oncology (Thyroid) Dna And Mrna Of 112 Genes Next-Generation Sequencing Fine Needle Aspirate Of Thyroid Nodule Algorithmic Analysis Reported As A Categorical Result (Positive High Probability Of Malignancy Or Negative Low Probability Of Malignancy)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0027U	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene Analysis Targeted Sequence Analysis Exons 12-15	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0029U	Drug Metabolism (Adverse Drug Reactions And Drug Response) Targeted Sequence Analysis (Ie Cyp1A2 Cyp2C19 Cyp2C9 Cyp2D6 Cyp3A4 Cyp3A5 Cyp4F2 Slco1B1 Vkorc1 And Rs12777823)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0030U	Drug Metabolism (Warfarin Drug Response) Targeted Sequence Analysis (Ie Cyp2C9 Cyp4F2 Vkorc1 Rs12777823)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0031U	Cyp1A2 (Cytochrome P450 Family 1 Subfamily A Member 2)(Eg Drug Metabolism) Gene Analysis Common Variants (Ie *1F *1K *6 *7)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0032U	Comt (Catechol-O-Methyltransferase)(Drug Metabolism) Gene Analysis C.472G>A (Rs4680) Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0033U	Htr2A (5-Hydroxytryptamine Receptor 2A) Htr2C (5-Hydroxytryptamine Receptor 2C) (Eg Citalopram Metabolism) Gene Analysis Common Variants (Ie Htr2A Rs7997012 [C.614-2211T>C] Htr2C Rs3813929 [C.-759C>T] And Rs1414334 [C.551-3008C>G])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0034U	Tpmt (Thiopurine S-Methyltransferase) Nudt15 (Nudix Hydroxylase 15)(Eg Thiopurine Metabolism) Gene Analysis Common Variants (Ie Tpmt *2 *3A *3B *3C *4 *5 *6 *8 *12; Nudt15 *3 *4 *5)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0036U	Exome (Ie Somatic Mutations) Paired Formalin-Fixed Paraffin-Embedded Tumor Tissue And Normal Specimen Sequence Analyses	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0037U	Targeted Genomic Sequence Analysis Solid Organ Neoplasm Dna Analysis Of 324 Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0040U	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis Major Breakpoint Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0045U	Oncology (Breast Ductal Carcinoma In Situ) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 12 Genes (7 Content And 5 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0046U	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Internal Tandem Duplication (Itd) Variants Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0047U	Oncology (Prostate) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 17 Genes (12 Content And 5 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0048U	Oncology (Solid Organ Neoplasia) Dna Targeted Sequencing Of Protein-Coding Exons Of 468 Cancer-Associated Genes Including Interrogation For Somatic Mutations And Microsatellite Instability Matched With Normal Specimens Utilizing Formalin-Fixed Paraffin-Embedded Tumor Tissue Report Of Clinically Significant Mutation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0049U	Npm1 (Nucleophosmin) (Eg Acute Myeloid Leukemia) Gene Analysis Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0050U	Targeted Genomic Sequence Analysis Panel Acute Myelogenous Leukemia Dna Analysis 194 Genes Interrogation For Sequence Variants Copy Number Variants Or Rearrangements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2018	12/31/2999

0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0055U	Cardiology (Heart Transplant) Cell-Free Dna Pcr Assay Of 96 Dna Target Sequences (94 Single Nucleotide Polymorphism Targets And Two Control Targets) Plasma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0060U	Twin Zygosity Genomic Targeted Sequence Analysis Of Chromosome 2 Using Circulating Cell-Free Fetal Dna In Maternal Blood	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0063U	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
0069U	Oncology (Colorectal) Microrna Rt-Pcr Expression Profiling Of Mir-31-3P Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As An Expression Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0070U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Common And Select Rare Variants (Ie *2 *3 *4 *4N *5 *6 *7 *8 *9 *10 *11 *12 *13 *14A *14B *15 *17 *29 *35 *36 *41 *57 *61 *63 *68 *83 *Xn)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
0071U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Full Gene Sequence (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
0072U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Targeted Sequence Analysis (Ie Cyp2D6-2D7 Hybrid Gene) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0073U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Targeted Sequence Analysis (Ie Cyp2D7-2D6 Hybrid Gene) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0074U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Targeted Sequence Analysis (Ie Non-Duplicated Gene When Duplication/Multiplication Is Trans) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999

0075U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Targeted Sequence Analysis (Ie 5' Gene Duplication/Multiplication) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
0076U	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Targeted Sequence Analysis (Ie 3' Gene Duplication/ Multiplication) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0078U	Pain Management (Opioid-Use Disorder) Genotyping Panel 16 Common Variants (Ie Abcb1 Comt Dat1 Dbh Dor Drd1 Drd2 Drd4 Gaba Gal Htr2A Httlpr Mthfr Muor Oprk1 Oprm1) Buccal Swab Or Other Germline Tissue Sample Algorithm Reported As Positive Or Negative Risk Of Opioid-Use Disorder	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2008	12/31/2999
0079U	Comparative Dna Analysis Using Multiple Selected Single-Nucleotide Polymorphisms (Snps) Urine And Buccal Dna For Specimen Identity Verification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999

0086U	Infectious disease (bacterial and fungal), organism identification, blood culture, using rRNA FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial susceptibility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
0087U	Cardiology (Heart Transplant) Mrna Gene Expression Profiling By Microarray Of 1283 Genes Transplant Biopsy Tissue Allograft Rejection And Injury Algorithm Reported As A Probability Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0088U	Transplantation Medicine (Kidney Allograft Rejection) Microarray Gene Expression Profiling Of 1494 Genes Utilizing Transplant Biopsy Tissue Algorithm Reported As A Probability Score For Rejection	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0089U	Oncology (Melanoma) Gene Expression Profiling By Rtqpcr Prame And Linc00518 Superficial Collection Using Adhesive Patch(Es)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0090U	Oncology (Cutaneous Melanoma) Mrna Gene Expression Profiling By Rt-Pcr Of 23 Genes (14 Content And 9 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue (Ffpe) Algorithm Reported As A Categorical Result (Ie Benign Intermediate Malignant)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
0092U	Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999

0094U	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Rapid Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0095T	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0095U	Eosinophilic esophagitis, (Eotaxin-3 [CCL26 {C-C motif chemokine ligand 26}] and major basic protein [PRG2 {proteoglycan 2, pro eosinophil major basic protein}], enzyme-linked immunosorbent assays (ELISA), specimen obtained by esophageal string test device, algorithm reported as probability of active or inactive eosinophilic esophagitis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
0096U	Human papillomavirus (HPV), high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68), male urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
0098T	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

0101U	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis) Genomic Sequence Analysis Panel Utilizing A Combination Of Ngs Sanger Mlpa And Array Cgh With Mrna Analytics To Resolve Variants Of Unknown Significance When Indicated (15 Genes [Sequencing And Deletion/Duplication] Epcam And Grem1 [Deletion/Duplication Only])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0102U	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Genomic Sequence Analysis Panel Utilizing A Combination Of Ngs Sanger Mlpa And Array Cgh With Mrna Analytics To Resolve Variants Of Unknown Significance When Indicated (17 Genes [Sequencing And Deletion/Duplication])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0103U	Hereditary Ovarian Cancer (Eg Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Genomic Sequence Analysis Panel Utilizing A Combination Of Ngs Sanger Mlpa And Array Cgh With Mrna Analytics To Resolve Variants Of Unknown Significance When Indicated (24 Genes [Sequencing And Deletion/Duplication] Epcam [Deletion/Duplication Only])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0107U	Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0108U	Gastroenterology (Barrett?s esophagus), whole slide?digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999

0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0109U	Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger, and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0110U	Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0111U	Oncology (Colon Cancer) Targeted Kras (Codons 12 13 And 61) And Nras (Codons 12 13 And 61) Gene Analysis Utilizing Formalin-Fixed Paraffin-Embedded Tissue	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0113U	Oncology (Prostate) Measurement Of Pca3 And Tmprss2-Erg In Urine And Psa In Serum Following Prostatic Massage By Rna Amplification And Fluorescence-Based Detection Algorithm Reported As Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0114U	Gastroenterology (Barrett'S Esophagus) Vim And Ccna1 Methylation Analysis Esophageal Cells Algorithm Reported As Likelihood For Barrett'S Esophagus	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0115U	Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0116U	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0118U	Transplantation Medicine Quantification Of Donor-Derived Cell-Free Dna Using Whole Genome Next-Generation Sequencing Plasma Reported As Percentage Of Donor-Derived Cell-Free Dna In The Total Cell-Free Dna	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0119U	Cardiology, ceramides by liquid chromatography?tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999

0120U	Oncology (B-Cell Lymphoma Classification) Mrna Gene Expression Profiling By Fluorescent Probe Hybridization Of 58 Genes (45 Content And 13 Housekeeping Genes) Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Likelihood For Primary Mediastinal B-Cell Lymphoma (Pmbcl) And Diffuse Large B-Cell Lymphoma (Dlbcl) With Cell Of Origin Subtyping In The Latter	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0121U	Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0122U	Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0123U	Mechanical fragility, RBC, shear stress and spectral analysis profiling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2019	12/31/2999
0129U	Hereditary Breast Cancer–Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Genomic Sequence Analysis And Deletion/Duplication Analysis Panel (Atm Brca1 Brca2 Cdh1 Chek2 Palb2 Pten And Tp53)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0130U	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis) Targeted Mrna Sequence Analysis Panel (Apc Cdh1 Chek2 Mlh1 Msh2 Msh6 Mutyh Pms2 Pten And Tp53) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0131U	Hereditary Breast Cancer–Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Targeted Mrna Sequence Analysis Panel (13 Genes) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0132U	Hereditary Ovarian Cancer–Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Targeted Mrna Sequence Analysis Panel (17 Genes) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0133U	Hereditary Prostate Cancer–Related Disorders Targeted Mrna Sequence Analysis Panel (11 Genes) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0134U	Hereditary Pan Cancer (Eg Hereditary Breast And Ovarian Cancer Hereditary Endometrial Cancer Hereditary Colorectal Cancer) Targeted Mrna Sequence Analysis Panel (18 Genes) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0135U	Hereditary Gynecological Cancer (Eg Hereditary Breast And Ovarian Cancer Hereditary Endometrial Cancer Hereditary Colorectal Cancer) Targeted Mrna Sequence Analysis Panel (12 Genes) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0136U	Atm (Ataxia Telangiectasia Mutated) (Eg Ataxia Telangiectasia) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0137U	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And Pancreatic Cancer) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0138U	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0142U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0152U	Infectious disease (bacteria, fungi, parasites, and DNA viruses), microbial cell-free DNA, plasma, untargeted next-generation sequencing, report for significant positive pathogens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0153U	Oncology (Breast) Mrna Gene Expression Profiling By Next-Generation Sequencing Of 101 Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Triple Negative Breast Cancer Clinical Subtype(S) With Information On Immune Cell Involvement	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0154U	Oncology (Urothelial Cancer) Rna Analysis By Real-Time Rt-Pcr Of The Fgfr3 (Fibroblast Growth Factor Receptor 3) Gene Analysis (Ie P.R248C [C.742C>T] P.S249C [C.746C>G] P.G370C [C.1108G>T] P.Y373C [C.1118A>G] Fgfr3-Tacc3V1 And Fgfr3-Tacc3V3) Utilizing Formalin-Fixed Paraffin-Embedded Urothelial Cancer Tumor Tissue Reported As Fgfr Gene Alteration Status	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0155U	Oncology (Breast Cancer) Dna Pik3Ca (Phosphatidylinositol-4 5-Bisphosphate 3-Kinase Catalytic Subunit Alpha) (Eg Breast Cancer) Gene Analysis (Ie P.C420R P.E542K P.E545A P.E545D [G.1635G>T Only] P.E545G P.E545K P.Q546E P.Q546R P.H1047L P.H1047R P.H1047Y) Utilizing Formalin-Fixed Paraffin-Embedded Breast Tumor Tissue Reported As Pik3Ca Gene Mutation Status	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0156U	Copy Number (Eg Intellectual Disability Dysmorphology) Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0157U	Apc (Apc Regulator Of Wnt Signaling Pathway) (Eg Familial Adenomatosis Polyposis [Fap]) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0158U	Mlh1 (Mutl Homolog 1) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0159U	Msh2 (Muts Homolog 2) (Eg Hereditary Colon Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0160U	Msh6 (Muts Homolog 6) (Eg Hereditary Colon Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0161U	Pms2 (Pms1 Homolog 2 Mismatch Repair System Component) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0162U	Hereditary Colon Cancer (Lynch Syndrome) Targeted Mrna Sequence Analysis Panel (Mlh1 Msh2 Msh6 Pms2) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0164T	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0165T	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0169U	Nudt15 (Nudix Hydrolase 15) And Tpmt (Thiopurine S-Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0170U	Neurology (Autism Spectrum Disorder [Asd]) Rna Next-Generation Sequencing Saliva Algorithmic Analysis And Results Reported As Predictive Probability Of Asd Diagnosis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0171U	Targeted Genomic Sequence Analysis Panel Acute Myeloid Leukemia Myelodysplastic Syndrome And Myeloproliferative Neoplasms Dna Analysis 23 Genes Interrogation For Sequence Variants Rearrangements And Minimal Residual Disease Reported As Presence/Absence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0203U	Autoimmune (Inflammatory Bowel Disease) Mrna Gene Expression Profiling By Quantitative Rt-Pcr 17 Genes (15 Target And 2 Reference Genes) Whole Blood Reported As A Continuous Risk Score And Classification Of Inflammatory Bowel Disease Aggressiveness	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0204U	Oncology (Thyroid) Mrna Gene Expression Analysis Of 593 Genes (Including Braf Ras Ret Pax8 And Ntrk) For Sequence Variants And Rearrangements Utilizing Fine Needle Aspirate Reported As Detected Or Not Detected	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0205U	Ophthalmology (Age-Related Macular Degeneration) Analysis Of 3 Gene Variants (2 Cfh Gene 1 Arms2 Gene) Using Pcr And Maldi-Tof Buccal Swab Reported As Positive Or Negative For Neovascular Age-Related Macular-Degeneration Risk Associated With Zinc Supplements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0209U	Cytogenomic Constitutional (Genome-Wide) Analysis Interrogation Of Genomic Regions For Copy Number Structural Changes And Areas Of Homozygosity For Chromosomal Abnormalities	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0211U	Oncology (Pan-Tumor) Dna And Rna By Next-Generation Sequencing Utilizing Formalin-Fixed Paraffin-Embedded Tissue Interpretative Report For Single Nucleotide Variants Copy Number Alterations Tumor Mutational Burden And Microsatellite Instability With Therapy Association	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0212U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Proband	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0213T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0213U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Genome (Eg Parent Sibling)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0214T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0214U	Rare Diseases (Constitutional/Heritable Disorders) Whole Exome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Proband	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0215T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0215U	Rare Diseases (Constitutional/Heritable Disorders) Whole Exome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Exome (Eg Parent Sibling)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0216T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0216U	Neurology (Inherited Ataxias) Genomic Dna Sequence Analysis Of 12 Common Genes Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0217T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0217U	Neurology (Inherited Ataxias) Genomic Dna Sequence Analysis Of 51 Genes Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0218T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0218U	Neurology (Muscular Dystrophy) Dmd Gene Sequence Analysis Including Small Sequence Changes Deletions Duplications And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Characterization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
0228U	Oncology (Prostate) Multianalyte Molecular Profile By Photometric Detection Of Macromolecules Adsorbed On Nanosponge Array Slides With Machine Learning Utilizing First Morning Voided Urine Algorithm Reported As Likelihood Of Prostate Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0229U	Bcat1 (Branched Chain Amino Acid Transaminase 1) And Ikzf1 (Ikaros Family Zinc Finger 1) (Eg Colorectal Cancer) Promoter Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0230U	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) Full Sequence Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Expansions Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0231U	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha 1A) (Eg Spinocerebellar Ataxia) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Gene Expansions Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0232U	Cstb (Cystatin B) (Eg Progressive Myoclonic Epilepsy Type 1A Unverricht-Lundborg Disease) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Expansions Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0233U	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Expansions Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0234U	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0235U	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0236U	Smn1 (Survival Of Motor Neuron 1 Telomeric) And Smn2 (Survival Of Motor Neuron 2 Centromeric) (Eg Spinal Muscular Atrophy) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Duplications Deletions And Mobile Element Insertions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0237U	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia) Genomic Sequence Analysis Panel Including Ank2 Casq2 Cav3 Kcne1 Kcne2 Kcnh2 Kcnj2 Kcnq1 Ryr2 And Scn5A Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0238U	Oncology (Lynch Syndrome) Genomic Dna Sequence Analysis Of Mlh1 Msh2 Msh6 Pms2 And Epcam Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0239U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Dna Analysis Of 311 Or More Genes Interrogation For Sequence Variants Including Substitutions Insertions Deletions Select Rearrangements And Copy Number Variations	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0242U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Circulating Dna Analysis Of 55-74 Genes Interrogation For Sequence Variants Gene Copy Number Amplifications And Gene Rearrangements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0244U	Oncology (Solid Organ) Dna Comprehensive Genomic Profiling 257 Genes Interrogation For Single-Nucleotide Variants Insertions/Deletions Copy Number Alterations Gene Rearrangements Tumor-Mutational Burden And Microsatellite Instability Utilizing Formalin-Fixed Paraffin-Embedded Tumor Tissue	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0245U	Oncology (Thyroid) Mutation Analysis Of 10 Genes And 37 Rna Fusions And Expression Of 4 Mrna Markers Using Next-Generation Sequencing Fine Needle Aspirate Report Includes Associated Risk Of Malignancy Expressed As A Percentage	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0250U	Oncology (Solid Organ Neoplasm) Targeted Genomic Sequence Dna Analysis Of 505 Genes Interrogation For Somatic Alterations (Snvs [Single Nucleotide Variant] Small Insertions And Deletions One Amplification And Four Translocations) Microsatellite Instability And Tumor-Mutation Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0252U	Fetal Aneuploidy Short Tandem–Repeat Comparative Analysis Fetal Dna From Products Of Conception Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploidy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
0253U	Reproductive Medicine (Endometrial Receptivity Analysis) Rna Gene Expression Profile 238 Genes By Next-Generation Sequencing Endometrial Tissue Predictive Algorithm Reported As Endometrial Window Of Implantation (Eg Pre-Receptive Receptive Post-Receptive)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0254U	Reproductive Medicine (Preimplantation Genetic Assessment) Analysis Of 24 Chromosomes Using Embryonic Dna Genomic Sequence Analysis For Aneuploidy And A Mitochondrial Dna Score In Euploid Embryos Results Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploidy Per Embryo Tested	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0258U	Autoimmune (Psoriasis) Mrna Next-Generation Sequencing Gene Expression Profiling Of 50-100 Genes Skin-Surface Collection Using Adhesive Patch Algorithm Reported As Likelihood Of Response To Psoriasis Biologics	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0260U	Rare Diseases (Constitutional/Heritable Disorders) Identification Of Copy Number Variations Inversions Insertions Translocations And Other Structural Variants By Optical Genome Mapping	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0262U	Oncology (Solid Tumor) Gene Expression Profiling By Real-Time Rt-Pcr Of 7 Gene Pathways (Er Ar Pi3K Mapk Hh Tgfb Notch) Formalin-Fixed Paraffin-Embedded (Ffpe) Algorithm Reported As Gene Pathway Activity Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0264U	Rare Diseases (Constitutional/Heritable Disorders) Identification Of Copy Number Variations Inversions Insertions Translocations And Other Structural Variants By Optical Genome Mapping	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

0265U	Rare Constitutional And Other Heritable Disorders Whole Genome And Mitochondrial Dna Sequence Analysis Blood Frozen And Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Saliva Buccal Swabs Or Cell Lines Identification Of Single Nucleotide And Copy Number Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0266U	Unexplained Constitutional Or Other Heritable Disorders Or Syndromes Tissue-Specific Gene Expression By Whole-Transcriptome And Next-Generation Sequencing Blood Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Or Fresh Frozen Tissue Reported As Presence Or Absence Of Splicing Or Expression Changes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0267U	Rare Constitutional And Other Heritable Disorders Identification Of Copy Number Variations Inversions Insertions Translocations And Other Structural Variants By Optical Genome Mapping And Whole Genome Sequencing	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0268U	Hematology (Atypical Hemolytic Uremic Syndrome [Ahus]) Genomic Sequence Analysis Of 15 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0269U	Hematology (Autosomal Dominant Congenital Thrombocytopenia) Genomic Sequence Analysis Of 22 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0270U	Hematology (Congenital Coagulation Disorders) Genomic Sequence Analysis Of 20 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0271U	Hematology (Congenital Neutropenia) Genomic Sequence Analysis Of 24 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999

0272U	Hematology (Genetic Bleeding Disorders) Genomic Sequence Analysis Of 60 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid Comprehensive	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0273U	Hematology (Genetic Hyperfibrinolysis Delayed Bleeding) Genomic Sequence Analysis Of 8 Genes (F13A1 F13B Fga Fgb Fgg Serpina1 Serpine1 Serpinf2 Plau) Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0274U	Hematology (Genetic Platelet Disorders) Genomic Sequence Analysis Of 62 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

0276U	Hematology (Inherited Thrombocytopenia) Genomic Sequence Analysis Of 42 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0277U	Hematology (Genetic Platelet Function Disorder) Genomic Sequence Analysis Of 40 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0278U	Hematology (Genetic Thrombosis) Genomic Sequence Analysis Of 14 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0285U	Oncology Response To Radiation Cell-Free Dna Quantitative Branched Chain Dna Amplification Plasma Reported As A Radiation Toxicity Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0286U	Cep72 (Centrosomal Protein 72-Kda) Nudt15 (Nudix Hydrolase 15) And Tpmt (Thiopurine S-Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0287U	Oncology (Thyroid) Dna And Mrna Next-Generation Sequencing Analysis Of 112 Genes Fine Needle Aspirate Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithmic Prediction Of Cancer Recurrence Reported As A Categorical Risk Result (Low Intermediate High)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0288U	Oncology (Lung) Mrna Quantitative Pcr Analysis Of 11 Genes (Bag1 Brca1 Cdc6 Cdk2Ap1 Erbb3 Fut3 Il11 Lck Rnd3 Sh3Bgr Wnt3A) And 3 Reference Genes (Esd Tbp Yap1) Formalin-Fixed Paraffin-Embedded (Ffpe) Tumor Tissue Algorithmic Interpretation Reported As A Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0289U	Neurology (Alzheimer Disease) Mrna Gene Expression Profiling By Rna Sequencing Of 24 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0290U	Pain Management Mrna Gene Expression Profiling By Rna Sequencing Of 36 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0291U	Psychiatry (Mood Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 144 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0292U	Psychiatry (Stress Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 72 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0293U	Psychiatry (Suicidal Ideation) Mrna Gene Expression Profiling By Rna Sequencing Of 54 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0294U	Longevity And Mortality Risk Mrna Gene Expression Profiling By Rna Sequencing Of 18 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0296U	Oncology (Oral And/Or Oropharyngeal Cancer) Gene Expression Profiling By Rna Sequencing At Least 20 Molecular Features (Eg Human And/Or Microbial Mrna) Saliva Algorithm Reported As Positive Or Negative For Signature Associated With Malignancy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0297U	Oncology (Pan Tumor) Whole Genome Sequencing Of Paired Malignant And Normal Dna Specimens Fresh Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0298U	Oncology (Pan Tumor) Whole Transcriptome Sequencing Of Paired Malignant And Normal Rna Specimens Fresh Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Expression Level And Chimeric Transcript Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0299U	Oncology (Pan Tumor) Whole Genome Optical Genome Mapping Of Paired Malignant And Normal Dna Specimens Fresh Frozen Tissue Blood Or Bone Marrow Comparative Structural Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0300U	Oncology (Pan Tumor) Whole Genome Sequencing And Optical Genome Mapping Of Paired Malignant And Normal Dna Specimens Fresh Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0306U	Oncology (Minimal Residual Disease [Mrd]) Next-Generation Targeted Sequencing Analysis Cell-Free Dna Initial (Baseline) Assessment To Determine A Patient Specific Panel For Future Comparisons To Evaluate For Mrd	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0307U	Oncology (Minimal Residual Disease [Mrd]) Next-Generation Targeted Sequencing Analysis Of A Patient-Specific Panel Cell-Free Dna Subsequent Assessment With Comparison To Previously Analyzed Patient Specimens To Evaluate For Mrd	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
0313U	Oncology (Pancreas) Dna And Mrna Next-Generation Sequencing Analysis Of 74 Genes And Analysis Of Cea (Ceacam5) Gene Expression Pancreatic Cyst Fluid Algorithm Reported As A Categorical Result (Ie Negative Low Probability Of Neoplasia Or Positive High Probability Of Neoplasia)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

0314U	Oncology (Cutaneous Melanoma) Mrna Gene Expression Profiling By Rt-Pcr Of 35 Genes (32 Content And 3 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithm Reported As A Categorical Result (Ie Benign Intermediate Malignant)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0315U	Oncology (Cutaneous Squamous Cell Carcinoma) Mrna Gene Expression Profiling By Rt-Pcr Of 40 Genes (34 Content And 6 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithm Reported As A Categorical Risk Result (Ie Class 1 Class 2A Class 2B)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0317U	Oncology (Lung Cancer) Four-Probe Fish (3Q29 3P22.1 10Q22.3 10Cen) Assay Whole Blood Predictive Algorithmgenerated Evaluation Reported As Decreased Or Increased Risk For Lung Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0318U	Pediatrics (Congenital Epigenetic Disorders) Whole Genome Methylation Analysis By Microarray For 50 Or More Genes Blood	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0319U	Nephrology (Renal Transplant) Rna Expression By Select Transcriptome Sequencing Using Pretransplant Peripheral Blood Algorithm Reported As A Risk Score For Early Acute Rejection	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0320U	Nephrology (Renal Transplant) Rna Expression By Select Transcriptome Sequencing Using Posttransplant Peripheral Blood Algorithm Reported As A Risk Score For Acute Cellular Rejection	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	1/14/2024

0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
0326U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Circulating Dna Analysis Of 83 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0327U	Fetal Aneuploidy (Trisomy 13 18 And 21) Dna Sequence Analysis Of Selected Regions Using Maternal Plasma Algorithm Reported As A Risk Score For Each Trisomy Includes Sex Reporting If Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0329U	Oncology (Neoplasia) Exome And Transcriptome Sequence Analysis For Sequence Variants Gene Copy Number Amplifications And Deletions Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden Utilizing Dna And Rna From Tumor With Dna From Normal Blood Or Saliva For Subtraction Report Of Clinically Significant Mutation(S) With Therapy Associations	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999

0331U	Oncology (Hematolymphoid Neoplasia) Optical Genome Mapping For Copy Number Alterations And Gene Rearrangements Utilizing Dna From Blood Or Bone Marrow Report Of Clinically Significant Alternations	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0332U	Oncology (Pan-Tumor) Genetic Profiling Of 8 Dna-Regulatory (Epigenetic) Markers By Quantitative Polymerase Chain Reaction (Qpcr) Whole Blood Reported As A High Or Low Probability Of Responding To Immune Checkpoint–Inhibitor Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0333U	Oncology (Liver) Surveillance For Hepatocellular Carcinoma (Hcc) In Highrisk Patients Analysis Of Methylation Patterns On Circulating Cell-Free Dna (Cfdna) Plus Measurement Of Serum Of Afp/Afp-L3 And Oncoprotein Des-Gammacarboxy-Prothrombin (Dcp) Algorithm Reported As Normal Or Abnormal Result	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0334U	Oncology (Solid Organ) Targeted Genomic Sequence Analysis Formalin-Fixed Paraffinembedded (Ffpe) Tumor Tissue Dna Analysis 84 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0335T	Insertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0335U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Fetal Sample Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0336U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Genome (Eg Parent)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

0339U	Oncology (Prostate) Mrna Expression Profiling Of Hoxc6 And Dlx1 Reverse Transcription Polymerase Chain Reaction (Rt-Pcr) First-Void Urine Following Digital Rectal Examination Algorithm Reported As Probability Of High-Grade Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0340U	Oncology (Pan-Cancer) Analysis Of Minimal Residual Disease (Mrd) From Plasma With Assays Personalized To Each Patient Based On Prior Next-Generation Sequencing Of The Patient'S Tumor And Germline Dna Reported As Absence Or Presence Of Mrd With Disease-Burden Correlation If Appropriate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0341U	Fetal Aneuploidy Dna Sequencing Comparative Analysis Fetal Dna From Products Of Conception Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0343U	Oncology (Prostate) Exosome-Based Analysis Of 442 Small Noncoding Rnas (Sncrnas) By Quantitative Reverse Transcription Polymerase Chain Reaction (Rt-Qpcr) Urine Reported As Molecular Evidence Of No- Low- Intermediate- Or High-Risk Of Prostate Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0345U	Psychiatry (Eg Depression Anxiety Attention Deficit Hyperactivity Disorder [Adhd]) Genomic Analysis Panel Variant Analysis Of 15 Genes Including Deletion/Duplication Analysis Of Cyp2D6	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

0347U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 16 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0348U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 25 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0349U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis Including Reported Phenotypes And Impacted Gene-Drug Interactions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0350U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0355U	Apol1 (Apolipoprotein L1) (Eg Chronic Kidney Disease) Risk Variants (G1 G2)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0356U	Oncology (Oropharyngeal Or Anal) Evaluation Of 17 Dna Biomarkers Using Droplet Digital Pcr (Ddpcr) Cell-Free Dna Algorithm Reported As A Prognostic Risk Score For Cancer Recurrence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0362U	Oncology (Papillary Thyroid Cancer) Gene-Expression Profiling Via Targeted Hybrid Capture– Enrichment Rna Sequencing Of 82 Content Genes And 10 Housekeeping Genes Fine Needle Aspirate Or Formalin-Fixed Paraffinembedded (Ffpe) Tissue Algorithm Reported As One Of Three Molecular Subtypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0363U	Oncology (Urothelial) Mrna Gene-Expression Profiling By Real-Time Quantitative Pcr Of 5 Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Incorporates Age Sex Smoking History And Macrohematuria Frequency Reported As A Risk Score For Having Urothelial Carcinoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0364U	Oncology (Hematolymphoid Neoplasm) Genomic Sequence Analysis Using Multiplex (Pcr) And Next-Generation Sequencing With Algorithm Quantification Of Dominant Clonal Sequence(S) Reported As Presence Or Absence Of Minimal Residual Disease (Mrd) With Quantitation Of Disease Burden When Appropriate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_

0368U	Oncology (Colorectal Cancer) Evaluation For Mutations Of Apc Braf Ctnnb1 Kras Nras Pik3Ca Smad4 And Tp53 And Methylation Markers (Myo1G Kcnq5 C9Orf50 Fli1 Clip4 Znf132 And Twist1) Multiplex Quantitative Polymerase Chain Reaction (Qpcr) Circulating Cell-Free Dna (Cfdna) Plasma Report Of Risk Score For Advanced Adenoma Or Colorectal Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0378U	Rfc1 (Replication Factor C Subunit 1) Repeat Expansion Variant Analysis By Traditional And Repeat-Primed Pcr Blood Saliva Or Buccal Swab	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0379U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Dna (523 Genes) And Rna (55 Genes) By Nextgeneration Sequencing Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
0380U	Drug Metabolism (Adverse Drug Reactions And Drug Response) Targeted Sequence Analysis 20 Gene Variants And Cyp2D6 Deletion Or Duplication Analysis With Reported Genotype And Phenotype	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
0394T	High Dose Rate Electronic Brachytherapy Skin Surface Application Per Fraction Includes Basic Dosimetry When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0395T	High Dose Rate Electronic Brachytherapy Interstitial Or Intracavitary Treatment Per Fraction Includes Basic Dosimetry When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2016	12/31/2999
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2020	12/31/2999
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999

0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0452U	Oncology (bladder), methylated PENK DNA detection by linear target enrichment-quantitative methylation-specific real-time PCR (LTE-qMSP), urine, reported as likelihood of bladder cancer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0453U	Oncology (colorectal cancer), cellfree DNA (cfDNA), methylation-based quantitative PCR assay (SEPTIN9, IKZF1, BCAT1, Septin9-2, VAV3, BCAN), plasma, reported as presence or absence of circulating tumor DNA (ctDNA)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0454U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0456U	Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_

0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0461U	Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with variant analysis, including impacted gene-drug interactions and reported phenotypes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0465U	Oncology (urothelial carcinoma), DNA, quantitative methylation-specific PCR of 2 genes (ONECUT2, VIM), algorithmic analysis reported as positive or negative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0466U	Cardiology (coronary artery disease [CAD]), DNA, genome-wide association studies (564856 single-nucleotide polymorphisms [SNPs], targeted variant genotyping), patient lifestyle and clinical data, buccal swab, algorithm reported as polygenic risk to acquired heart disease	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0467U	Oncology (bladder), DNA, next-generation sequencing (NGS) of 60 genes and whole genome aneuploidy, urine, algorithms reported as minimal residual disease (MRD) status positive or negative and quantitative disease burden	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_

0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants, duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance pattern that indicate uniparental disomy (UPD), and aneuploidy, fetal sample (amniotic fluid, chorionic villus sample, or products of conception), identification and categorization of genetic variants, diagnostic report of fetal results based on phenotype with maternal sample and paternal sample, if performed, as comparators and/or maternal cell contamination	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0471U	Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0473U	Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2017	12/31/2999
0474U	Hereditary pan-cancer (eg, hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next-generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0475U	Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999

0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999

0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
0507T	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2018	12/31/2999
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999

0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2024	9/30/2024
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2024	9/30/2024
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

0601T	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0615T	Eye-movement analysis without spatial calibration, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999

0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999

0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999

0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0665T	Donor hysterectomy (including cold preservation); open, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0692T	Therapeutic ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
07957	WEIGHT LOSS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999

0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	9/30/2024
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
213AA	Proc/Treat/Equip/Ins/Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213BA	OTC Drugs Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213CA	Vision/Hear/Dental Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213EA	Assit Disabled/Misc Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213FA	Corr Eye Surgery Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213GA	Premiums Non- Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213HA	Copays Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999

213JA	Limited Purpose HCA Non- Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213KA	Preventative Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
213LA	Long Term Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
9701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2014	12/31/2999
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0435	Fixed wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0888	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999

A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A2012	Suprathel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999

A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2024	Resolve matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999

A2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
A4100	Skin substitute, fda cleared as a device, not otherwise specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4342	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4458	Enema bag with tubing, reusable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4553	Non-disposable underpads, all sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

A4554	Disposable underpads, all sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2/7/2005	12/31/2999
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	1/14/2024
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
A4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories, per month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
A4638	Replacement battery for patient-owned ear pulse generator, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
A4639	Replacement pad for infrared heating pad system, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
A4890	Contracts, repair and maintenance, for hemodialysis equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4927	Gloves, non-sterile, per 100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4931	Oral thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4932	Rectal thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

A6000	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
A7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A9150	Non-prescription drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A9152	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A9153	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A9270	Non-covered item or service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
A9282	WIG, ANY TYPE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2022	12/31/2999
A9285	Inversion/eversion correction device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	1/31/2024
A9300	Exercise equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A9508	Iodine I-131 Iobenguane Sulfate Diagnostic Per 0.5 Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

A9513	Lutetium Lu 177 Dotatate Therapeutic 1 Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9528	Iodine I-131 Sodium Iodide Capsule(S) Diagnostic Per Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9531	Iodine I-131 Sodium Iodide Diagnostic Per Microcurie (Up To 100 Microcuries)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9543	Yttrium Y-90 Ibritumomab Tiuxetan Therapeutic Per Treatment Dose Up To 40 Millicuries	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9590	Iodine I-131 Iobenguane 1 Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9600	Strontium Sr-89 Chloride Therapeutic Per Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9602	Fluorodopa F-18 Diagnostic Per Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9604	Samarium Sm-153 Lexidronam Therapeutic Per Treatment Dose Up To 150 Millicuries	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9606	Radium Ra-223 Dichloride Therapeutic Per Microcurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
A9607	Lutetium Lu 177 Vipivotide Tetraxetan Therapeutic 1 Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

A9800	Gallium Ga-68 Gozetotide Diagnostic (Locametz) 1 Millicurie	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
C1761	Catheter, transluminal intravascular lithotripsy, coronary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
C1764	Event recorder, cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
C1778	Lead, neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999

C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
C1832	Autograft suspension, including cell processing and application, and all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024
C1832	Autograft suspension, including cell processing and application, and all system components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999

C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999

C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	3/31/2024
C9161	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	3/31/2024
C9168	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	6/30/2024
C9257	Injection Bevacizumab 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
C9257	Injection Bevacizumab 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9359	Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Putty Integra Os Osteoconductive Scaffold Putty) Per 0.5 Cc	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

C9362	Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Strip) Per 0.5 Cc	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9399	Unclassified Drugs Or Biologicals	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999

C9765	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9768	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
C9769	Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2020	12/31/2999
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9782	Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9786	Echocardiography image post processing for computer aided detection of heart failure with preserved ejection fraction, including interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999

C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
D1705	AstraZeneca Covid-19 vaccine administration ? first dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2021	12/31/2999
D1706	AstraZeneca Covid-19 vaccine administration ? second dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2021	12/31/2999
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D7230	removal of impacted tooth - partially bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
E0210	Electric heat pad, standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0217	Water circulating heat pad with pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0218	Fluid circulating cold pad with pump, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999

E0221	Infrared heating pad system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0231	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0232	Warming card for use with the non contact wound warming device and non contact wound warming wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0236	Pump for water circulating pad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0240	Bath/shower chair, with or without wheels, any size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0241	Bath tub wall rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0242	Bath tub rail, floor base	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0247	Transfer bench for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0273	Bed board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0274	Over-bed table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0315	Bed accessory: board, table, or support device, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999

E0316	Safety enclosure frame/canopy for use with hospital bed, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
E0485	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Prefabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
E0486	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999

E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
E0616	Implantable cardiac event recorder with memory, activator and programmer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0617	External defibrillator with integrated electrocardiogram analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
E0635	Patient lift, electric with seat or sling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
E0641	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
E0650	Pneumatic compressor, non-segmental home model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999

E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0672	Segmental gradient pressure pneumatic appliance, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0673	Segmental gradient pressure pneumatic appliance, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999

E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
E0677	Non-pneumatic sequential compression garment, trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
E0678	Non-pneumatic sequential compression garment, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0679	Non-pneumatic sequential compression garment, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0681	Non-pneumatic compression controller without calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0682	Non-pneumatic sequential compression garment, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2006	12/31/2999
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2006	12/31/2999
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2006	12/31/2999
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2006	12/31/2999
E0732	Cranial electrotherapy stimulation (ces) system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024

E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0740	Non-implanted pelvic floor electrical stimulator, complete system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0748	Osteogenesis Stimulator Electrical Non-Invasive Spinal Applications	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
E0749	Osteogenesis Stimulator Electrical Surgically Implanted	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
E0830	Ambulatory traction device, all types, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

E0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0855	Cervical traction equipment not requiring additional stand or frame	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0856	Cervical traction device, with inflatable air bladder(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0860	Traction equipment, overdoor, cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0890	Traction frame, attached to footboard, pelvic traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
E0942	Cervical head harness/halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0944	Pelvic belt/harness/boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0985	Wheelchair accessory, seat lift mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0986	Manual wheelchair accessory, push-rim activated power assist system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1002	Wheelchair accessory, power seating system, tilt only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1005	Wheelchair accessory, power seatng system, recline only, with power shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
E1161	Manual adult size wheelchair, includes tilt in space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1230	Power operated vehicle (three or four wheel nonhighway) specify brand name and model number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1301	Whirlpool tub, walk-in, portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/24/2024	12/31/2999

E1629	Tablo hemodialysis system for the billable dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
E1700	Jaw motion rehabilitation system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	6/30/2024
E1701	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	6/30/2024
E1702	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	6/30/2024
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E2300	Wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	3/31/2024
E2301	Wheelchair accessory, power standing system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2007	12/31/2999

E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2007	12/31/2999
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2324	Power wheelchair accessory, chin cup for chin control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999

E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2511	Speech generating software program, for personal computer or personal digital assistant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2512	Accessory for speech generating device, mounting system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2599	Accessory for speech generating device, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2610	WHEELCHAIR SEAT CUSHION, POWERED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E3000	Speech volume modulation system, any type, including all components and accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
E3000	Speech volume modulation system, any type, including all components and accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2006	12/31/2999
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
G0255	Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999

G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
G0277	Hyperbaric Oxygen Under Pressure Full Body Chamber Per 30 Minute Interval	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in g0281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
G0289	Arthroscopy Knee Surgical For Removal Of Loose Body Foreign Body Debridement/Shaving Of Articular Cartilage (Chrondroplasty) At The Time Of Other Surgical Knee Arthroscopy In A Different Compartment Of The Same Knee	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
G0339	Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Complete Course Of Therapy In One Session Or First Session Of Fractionated Treatment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G0340	Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Delivery Including Collimator Changes And Custom Plugging Fractionated Treatment All Lesions Per Session Second Through Fifth Sessions Maximum Five Sessions Per Course Of Treatment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0422	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
G0423	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
G0458	Low Dose Rate (Ldr) Prostate Brachytherapy Services Composite Rate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
G2011	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999

G6001	Ultrasonic Guidance For Placement Of Radiation Therapy Fields	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6002	Stereoscopic X-Ray Guidance For Localization Of Target Volume For The Delivery Of Radiation Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6003	Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: Up To 5Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6004	Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 6-10Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6005	Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 11-19Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6006	Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 20Mev Or Greater	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6007	Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: Up To 5Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6008	Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 6-10Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6009	Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 11-19Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6010	Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 20 Mev Or Greater	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

G6011	Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; Up To 5Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6012	Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 6-10Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6013	Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 11-19Mev	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6014	Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 20Mev Or Greater	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6015	Intensity Modulated Treatment Delivery Single Or Multiple Fields/Arcs Via Narrow Spatially And Temporally Modulated Beams Binary Dynamic Mlc Per Treatment Session	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6016	Compensator-Based Beam Modulation Treatment Delivery Of Inverse Planned Treatment Using 3 Or More High Resolution (Milled Or Cast) Compensator Convergent Beam Modulated Fields Per Treatment Session	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G6017	Intra-Fraction Localization And Tracking Of Target Or Patient Motion During Delivery Of Radiation Therapy (Eg 3D Positional Tracking Gating 3D Surface Tracking) Each Fraction Of Treatment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

G8399	Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8400	Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8415	FOOTWEAR EVALUATION WAS NOT PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8416	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8417	Bmi is documented above normal parameters and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8418	Bmi is documented below normal parameters and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8419	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8420	Bmi is documented within normal parameters and no follow-up plan is required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8421	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8428	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8430	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

G8432	Depression screening not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8433	Screening for depression not completed, documented patient or medical reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8451	Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8452	Beta-blocker therapy not prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8474	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8478	Blood pressure measurement not performed or documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

G8482	INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY RECEIVED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8483	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8484	Influenza immunization was not administered, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G9050	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9051	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9053	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9056	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9058	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9059	Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9060	Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9061	Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9062	Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9063	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage i (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9064	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage ii (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9065	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9066	Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9067	Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9068	Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9069	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9070	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9071	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9072	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9073	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9074	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9075	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9077	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9078	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9079	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9080	Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9083	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9084	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9085	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9086	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9087	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9088	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9089	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9090	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9091	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9092	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9093	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9094	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9095	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9099	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9100	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9101	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9102	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9103	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9104	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9105	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9106	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9107	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9108	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9109	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9110	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9111	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9112	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9113	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9114	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9115	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9116	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9117	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9123	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9124	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9125	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9126	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9128	Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage i (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9129	Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9130	Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999

G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999

G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48 HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS PREVENT TRANSFER; PAYMENT IS MADE ON EACH PERIOD UP TO 4 HOURS, AFTER THE FIRST 4 HOURS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2007	12/31/2999
G9143	Warfarin Responsiveness Testing By Genetic Technique Using Any Method Any Number Of Specimen(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

G9978	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999

G9979	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: An expanded problem focused history;An expanded problem focused examination;Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999
G9980	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A detailed history;A detailed examination; Medical decision making of low complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999

G9981	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999
G9982	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of high complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999

G9983	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A problem focused history;A problem focused examination;Straightforward medical decision making, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999
G9984	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: An expanded problem focused history;An expanded problem focused examination;Medical decision making of low complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999

G9985	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A detailed history; A detailed examination;Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999
G9986	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of high complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999

G9987	Bundled Payments for Care Improvement Advanced (BPCI Advanced) model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only for a BPCI Advanced model episode of care; may not be billed for a 30-day period covered by a transitional care management code.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2018	12/31/2999
J0129	Injection Abatacept 10 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J0174	Injection, lecanemab-irmb, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2023	12/31/2999
J0177	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
J0178	Injection, aflibercept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J0179	Injection, brolucizumab-dbll, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J0202	Injection, alemtuzumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	6/14/2024

J0202	Injection Alemtuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0219	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
J0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J0222	Injection Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0223	Injection, givosiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
J0223	Injection Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0224	Injection, lumasiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999

J0224	Injection Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0225	Injection, vutrisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
J0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
J0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J0490	Injection Belimumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0491	Injection Anifrolumab-Fnia 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0517	Injection Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0565	Injection, bezlotoxumab, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	3/31/2024

J0565	Injection Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J0565	Injection Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0567	Injection, cerliponase alfa, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	3/31/2024
J0567	Injection Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0584	Injection, burosumab-twza 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	4/30/2024
J0584	Injection Burosumab-Twza 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
J0586	Injection Abobotulinumtoxina 5 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	1/31/2024

J0587	Injection Rimabotulinumtoxinb 100 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	1/31/2024
J0588	Injection Incobotulinumtoxin A 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
J0717	Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	6/14/2024
J0717	Injection Certolizumab Pegol 1 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	3/14/2024
J0741	Injection, cabotegravir and rilpivirine, 2mg/3mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
J0775	Injection Collagenase Clostridium Histolyticum 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_

J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
J0791	Injection Crizanlizumab-Tmca 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J0881	Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
J1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J1303	Injection Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999

J1305	Injection Evinacumab-Dgnb 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1306	Injection, inclisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1306	Injection Inclisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1325	Injection, epoprostenol, 0. 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J1325	Injection Epoprostenol 0. 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1426	Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1427	Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
J1428	Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999

J1428	Injection Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1429	Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1551	Injection Immune Globulin (Cutaquig) 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
J1554	Injection Immune Globulin (Asceniv) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1566	Injection Immune Globulin Intravenous Lyophilized (E. G. Powder) Not Otherwise Specified 500 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J1599	Injection Immune Globulin Intravenous Non-Lyophilized (E.G. Liquid) Not Otherwise Specified 500 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
J1632	Injection, brexanolone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999

J1675	Injection Histrelin Acetate 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1746	Injection, ibalizumab-uiyk, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	3/31/2024
J1746	Injection Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
J1823	Injection Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J1930	INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J1950	Injection Leuprolide Acetate (For Depot Suspension) Per 3. 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999

J1954	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
J2182	Injection Mepolizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2006	5/31/2024
J2278	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J2278	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	5/31/2024
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
J2329	Injection, ublituximab-xiiy, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2356	Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

J2356	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J2440	Injection, papaverine hcl, up to 60 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2007	12/31/2999
J2502	Injection, pasireotide long acting, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	4/30/2024
J2502	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J2502	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/30/2024
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J2777	Injection, faricimab-svoa, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J2782	Injection, avacincaptad pegol, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
J2796	INJECTION, ROMIPLOSTIM, 10 MICROGRAMS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
J3032	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3111	Injection, romosozumab-aqqg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J3121	Injection, testosterone enanthate, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
J3121	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J3121	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3145	Injection, testosterone undecanoate, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	3/31/2024
J3145	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J3145	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3241	Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999

J3241	Injection Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3245	Injection, tildrakizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	5/31/2024
J3245	Injection Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	5/31/2024
J3247	Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2024	12/31/2999
J3263	Loqtorzi (toripalimab-tpzi)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.		_
J3285	Injection Treprostinil 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J3285	Injection Treprostinil 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2022	12/31/2999
J3315	Injection Triptorelin Pamoate 3. 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024

J3380	Injection Vedolizumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3393	Injection, betibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J3396	INJECTION, VERTEPORFIN, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J3398	Injection Voretigene Neparvovec-Rzyl 1 Billion Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J3399	Injection Onasemnogene Abeparvovec-Xioi Per Treatment Up To 5X10^15 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J3490	Unclassified Drugs	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
J3520	Edetate disodium, per 150 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

J3570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2015	12/31/2999
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J7178	Injection, human fibrinogen concentrate, not otherwise specified, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	6/30/2024
J7178	Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J7178	Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J7309	METHYL AMINOLEVULINATE (MAL) FOR TOPICAL ADMINISTRATION, 16.8%, 1 GRAM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
J7316	Injection, ocriplasmin, 0.125 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
J7330	Autologous Cultured Chondrocytes Implant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
J7340	Carbidopa 5 Mg/Levodopa 20 Mg Enteral Suspension 100 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024

J7402	Mometasone furoate sinus implant, (sinuva), 10 micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7680	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7681	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J9035	Injection Bevacizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J9037	Injection, belantamab mafodontin-blmf, 0.5 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9057	Injection, copanlisib, 1 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9155	Injection Degarelix 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9202	Goserelin Acetate Implant Per 3. 6 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024

J9217	Leuprolide Acetate (For Depot Suspension) 7. 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9218	Leuprolide Acetate Per 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9219	Leuprolide Acetate Implant 65 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9225	Histrelin Implant (Vantas) 50 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9226	Histrelin Implant (Supprelin La) 50 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
J9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2021	12/31/2999
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J9332	Injection Efgartigimod Alfa-Fcab 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
J9333	Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999

J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J9345	Injection Retifanlimab-Dlwr 1 Mg	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
J9350	Injection Mosunetuzumab-Axgb 1 Mg	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	_
J9361	Ryzneuta (efbemalenograstim alfa-vuxw)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.		_
J9376	Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2024	12/31/2999
J9381	Injection, teplizumab-mzwv, 5 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J9999	Not Otherwise Classified Antineoplastic Drugs	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
K0005	Ultralightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
K0010	Standard - weight frame motorized/power wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0011	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

K0012	Lightweight portable motorized/power wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2013	12/31/2999
K0014	Other motorized/power wheelchair base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0053	Elevating footrests, articulating (telescoping), each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0065	Spoke protectors, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
K0108	Wheelchair component or accessory, not otherwise specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e. G. , epoprostenol or treprostinol)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0899	Power mobile device; no dme pdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

K1004	Low frequency ultrasonic diathermy treatment device for home use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	7/31/2024
K1027	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Without Fixed Mechanical Hinge Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2024	9/30/2024
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2007	12/31/2999
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2007	12/31/2999
L3060	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2007	12/31/2999
L5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999

L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5981	All lower extremity prostheses, flex-walk system or equal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7170	Electronic elbow, hosmer or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7360	Six volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
L7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7366	Battery charger, twelve volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
L8614	Cochlear Device Includes All Internal And External Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8615	Headset/Headpiece For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8616	Microphone For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_

L8617	Transmitting Coil For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8618	Transmitter Cable For Use With Cochlear Implant Device Or Auditory Osseointegrated Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8619	Cochlear Implant External Speech Processor And Controller Integrated System Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8621	Zinc Air Battery For Use With Cochlear Implant Device And Auditory Osseointegrated Sound Processors Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8622	Alkaline Battery For Use With Cochlear Implant Device Any Size Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8623	Lithium Ion Battery For Use With Cochlear Implant Device Speech Processor Other Than Ear Level Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8624	Lithium Ion Battery For Use With Cochlear Implant Or Auditory Osseointegrated Device Speech Processor Ear Level Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8627	Cochlear Implant External Speech Processor Component Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_

L8628	Cochlear Implant External Controller Component Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8629	Transmitting Coil And Cable Integrated For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8679	Implantable neurostimulator, pulse generator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8680	Implantable neurostimulator electrode, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8682	Implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999

L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
L8690	Auditory Osseointegrated Device Includes All Internal And External Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
L8691	Auditory Osseointegrated Device External Sound Processor Excludes Transducer/Actuator Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
L8693	Auditory Osseointegrated Device Abutment Any Length Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999

L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999

M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
P2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
P9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
P9099	Blood component or product not otherwise classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
Q0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0510	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH FOLLOWING transPLANT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
Q0511	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Q0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
Q2026	INJECTION, RADIESSE, 0.1 ML	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2013	12/31/2999
Q2028	Injection, sculptra, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2018	12/31/2999
Q2041	Axicabtagene Ciloleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2011	12/31/2999
Q2042	Tisagenlecleucel Up To 600 Million Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
Q2050	Injection Doxorubicin Hydrochloride Liposomal Not Otherwise Specified 10Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_
Q2052	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2014	12/31/2999
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999

Q2053	Brexucabtagene Autoleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
Q2054	Lisocabtagene Maraleucel Up To 110 Million Autologous Anti-Cd19 Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
Q2055	Idecabtagene Vicleucel Up To 460 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
Q2056	Ciltacabtagene Autoleucel Up To 100 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q3001	Radioelements For Brachytherapy Any Type Each	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999

Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4121	THERASKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	6/30/2024
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2021	12/31/2999
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4134	Hmatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4135	Mediskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4136	Ez-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4140	Biodfence, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4142	Xcm biologic tissue matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4146	Tensix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Q4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4151	Amnioband or guardian, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4153	Dermavest and plurivest, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4168	Amnioband, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4177	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4178	Floweramniopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4183	Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4186	Epifix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4193	Coll-e-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4194	Novachor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4197	Puraply xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4198	Genesis amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4199	Cygnus matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4209	Surgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	6/30/2024
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4212	Allogen, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4213	Ascent, 0.5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4216	Artacent cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4218	Surgicord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4219	Surgigraft-dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4221	Amniowrap2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4222	Progenamatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4225	Amniobind or dermabind tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4226	MyOwn skin, includes harvesting and preparation procedures, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	9/30/2024
Q4226	MyOwn skin, includes harvesting and preparation procedures, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4230	Cogenex flowable amnion, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4233	Surfactor or nudyn, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4237	Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2022	12/31/2999
Q4239	Amnio-maxx or amnio-maxx lite, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4240	Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4241	Polycyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	3/31/2024

Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4247	Amniotext patch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4248	Dermacyte amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4249	Amniply, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2022	12/31/2999
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2022	12/31/2999
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2022	12/31/2999
Q4254	Novafix dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999

Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4262	Dual layer impax membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4263	Surgraft tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999

Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	6/30/2024
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4279	Vendaje ac, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4282	Cygnus dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4283	Biovance tri-layer or biovance 3l, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999

Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4286	Nudyn sl or nudyn slw, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4287	Dermabind dl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4287	Dermabind dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4288	Dermabind ch, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4289	Revoshield + amniotic barrier, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4290	Membrane wrap-hydro, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4291	Lamellas xt, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4292	Lamellas, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4293	Acesso dl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4294	Amnio quad-core, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4294	Amnio quad-core, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4295	Amnio tri-core amniotic, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4296	Rebound matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024

Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4297	Emerge matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4298	Amnicore pro, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4299	Amnicore pro+, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4300	Acesso tl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4301	Activate matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4301	Activate matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4302	Complete aca, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4303	Complete aa, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
Q4303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4304	Grafix plus, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
Q4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4306	American amnion ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4307	American amnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4308	Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4310	Procenta, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999

Q4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4313	Dermabind fm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4314	Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4317	Vitograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4324	Amniotx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4328	Most, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q5103	Injection Infliximab-Dyyb Biosimilar (Inflectra) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q5104	Injection Infliximab-Abda Biosimilar (Renflexis) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q5106	Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2020	12/31/2999
Q5106	Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-Esrd Use) 1000 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
Q5109	Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999

Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
S0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
S0117	Tretinoin, topical, 5 grams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0142	COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2005	12/31/2999
S0157	Becaplermin gel 0. 01%, 0. 5 gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
S0157	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
S0157	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
S0189	Testosterone Pellet 75Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/1/2024
S0197	PRENATAL VITAMINS, 30-DAY SUPPLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2005	12/31/2999

S0310	Hospitalist services (list separately in addition to code for appropriate evaluation and management service)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0596	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
S0622	Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0800	Laser in situ keratomileusis (lasik)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
S1091	Stent, non-coronary, temporary, with delivery system (propel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S2102	Islet cell tissue transplant from pancreas; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2008	12/31/2999
S2120	Low density lipoprotein (ldl) apheresis using heparin-induced extracorporeal ldl precipitation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999

S2120	Low Density Lipoprotein (Ldl) Apheresis Using Heparin-Induced Extracorporeal Ldl Precipitation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_
S2140	Cord blood harvesting for transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2142	Cord blood-derived stem-cell transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S2230	Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S2235	Implantation of auditory brain stem implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2008	12/31/2999
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2400	Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999

S2402	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2409	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
S2900	Surgical techniques requiring use of robotic surgical system (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S3600	Stat laboratory request (situations other than s3601)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S3601	Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S3650	Saliva test, hormone level; during menopause	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S3652	Saliva test, hormone level; to assess preterm labor risk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S3800	Genetic Testing For Amyotrophic Lateral Sclerosis (Als)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	–	–

S3840	Dna Analysis For Germline Mutations Of The Ret Proto-Oncogene For Susceptibility To Multiple Endocrine Neoplasia Type 2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3841	Genetic Testing For Retinoblastoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3842	Genetic Testing For Von Hippel-Lindau Disease	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3844	Dna Analysis Of The Connexin 26 Gene (Gjb2) For Susceptibility To Congenital Profound Deafness	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3845	Genetic Testing For Alpha-Thalassemia	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3846	Genetic Testing For Hemoglobin E Beta-Thalassemia	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3849	Genetic Testing For Niemann-Pick Disease	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3850	Genetic Testing For Sickle Cell Anemia	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3852	Dna Analysis For Apoe Epsilon 4 Allele For Susceptibility To Alzheimer'S Disease	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3853	Genetic Testing For Myotonic Muscular Dystrophy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_

S3854	Gene Expression Profiling Panel For Use In The Management Of Breast Cancer Treatment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3861	Genetic Testing Sodium Channel Voltage-Gated Type V Alpha Subunit (Scn5A) And Variants For Suspected Brugada Syndrome	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3865	Comprehensive Gene Sequence Analysis For Hypertrophic Cardiomyopathy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3866	Genetic Analysis For A Specific Gene Mutation For Hypertrophic Cardiomyopathy (Hcm) In An Individual With A Known Hcm Mutation In The Family	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3870	Comparative Genomic Hybridization (Cgh) Microarray Testing For Developmental Delay Autism Spectrum Disorder And/Or Intellectual Disability	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S3900	Surface electromyography (emg)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
S4023	Donor egg cycle, incomplete, case rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4026	Procurement of donor sperm from sperm bank	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4027	Storage of previously frozen embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4030	Sperm procurement and cryopreservation services; initial visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

S4031	Sperm procurement and cryopreservation services; subsequent visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5035	Home infusion therapy, routine service of infusion device (e. G. Pump maintenance)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5036	Home infusion therapy, repair of infusion device (e. G. Pump repair)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5101	Day care services, adult; per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5102	Day care services, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5105	Day care services, center-based; services not included in program fee, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5109	Home care training to home care client, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5110	Home care training, family; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5111	Home care training, family; per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5116	Home care training, non-family; per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5120	Chore services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5121	Chore services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

S5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5135	Companion care, adult (e. G. Iadl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5136	Companion care, adult (e. G. Iadl/adl); per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5162	Emergency response system; purchase only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5165	Home modifications; per service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5199	Personal care item, nos, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

S8030	Scleral Application Of Tantalum Ring(S) For Localization Of Lesions For Proton Beam Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2005	12/31/2999
S8460	Camisole, post-mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S9090	Vertebral axial decompression, per session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
S9117	Back school, per visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S9125	Respite care, in the home, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9335	Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2008	12/31/2999
S9381	Delivery or service to high risk areas requiring escort or extra protection, per visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9436	Childbirth preparation/lamaze classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9437	Childbirth refresher classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9438	Cesarean birth classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9439	Vbac (vaginal birth after cesarean) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9442	Birthing classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9444	Parenting classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9446	Patient education, not otherwise classified, non-physician provider, group, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9447	Infant safety (including cpr) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9449	Weight management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

S9451	Exercise classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9454	Stress management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9472	Cardiac rehabilitation program, non-physician provider, per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S9562	Home injectable therapy, palivizumab or other monoclonal antibody for rsv, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9900	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9970	Health club membership, annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9975	Transplant related lodging, meals and transportation, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9976	Lodging, per diem, not otherwise classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9977	Meals, per diem, not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9981	Medical records copying fee, administrative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9982	Medical records copying fee, per page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9986	Not medically necessary service (patient is aware that service not medically necessary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9988	Services provided as part of a phase i clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

S9990	Services provided as part of a phase ii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9991	Services provided as part of a phase iii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9992	Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9994	Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9996	Meals for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9999	Sales tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
T1014	Telehealth transmission, per minute, professional services bill separately	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
T2101	Human breast milk processing, storage and distribution only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2019	12/31/2999
V2025	Deluxe frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
V2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
V2744	Tint, photochromatic, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2006	12/31/2999
V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2799	Vision item or service, miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2006	12/31/2999
V5095	Semi-implantable middle ear hearing prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
V5362	Speech screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

V5363	Language screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
70336	Magnetic Resonance (Eg Proton) Imaging Temporomandibular Joint(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70450	Computed Tomography Head Or Brain; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70460	Computed Tomography Head Or Brain; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70470	Computed Tomography Head Or Brain; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70480	Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70481	Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70482	Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

70486	Computed Tomography Maxillofacial Area; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70487	Computed Tomography Maxillofacial Area; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70488	Computed Tomography Maxillofacial Area; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70490	Computed Tomography Soft Tissue Neck; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70491	Computed Tomography Soft Tissue Neck; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70492	Computed Tomography Soft Tissue Neck; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70496	Computed Tomographic Angiography Head With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70498	Computed Tomographic Angiography Neck With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

70540	Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70542	Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70543	Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70544	Magnetic Resonance Angiography Head; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70545	Magnetic Resonance Angiography Head; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70546	Magnetic Resonance Angiography Head; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70547	Magnetic Resonance Angiography Neck; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70548	Magnetic Resonance Angiography Neck; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

70549	Magnetic Resonance Angiography Neck; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70551	Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70552	Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
70553	Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); Without Contrast Material Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71250	Computed Tomography Thorax Diagnostic; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71260	Computed Tomography Thorax Diagnostic; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71270	Computed Tomography Thorax Diagnostic; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71271	Computed Tomography Thorax Low Dose For Lung Cancer Screening Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

71275	Computed Tomographic Angiography Chest (Noncoronary) With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71550	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71551	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71552	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
71555	Magnetic Resonance Angiography Chest (Excluding Myocardium) With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72125	Computed Tomography Cervical Spine; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72126	Computed Tomography Cervical Spine; With Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72127	Computed Tomography Cervical Spine; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

72128	Computed Tomography Thoracic Spine; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72129	Computed Tomography Thoracic Spine; With Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72130	Computed Tomography Thoracic Spine; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72131	Computed Tomography Lumbar Spine; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72132	Computed Tomography Lumbar Spine; With Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72133	Computed Tomography Lumbar Spine; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72141	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Cervical; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72142	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Cervical; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

72146	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Thoracic; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72147	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Thoracic; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72148	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Lumbar; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72149	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Lumbar; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72156	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Cervical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72157	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72158	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72159	Magnetic Resonance Angiography Spinal Canal And Contents With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

72191	Computed Tomographic Angiography Pelvis With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72192	Computed Tomography Pelvis; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72193	Computed Tomography Pelvis; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72194	Computed Tomography Pelvis; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72195	Magnetic Resonance (Eg Proton) Imaging Pelvis; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72196	Magnetic Resonance (Eg Proton) Imaging Pelvis; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72197	Magnetic Resonance (Eg Proton) Imaging Pelvis; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
72198	Magnetic Resonance Angiography Pelvis With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

73200	Computed Tomography Upper Extremity; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73201	Computed Tomography Upper Extremity; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73202	Computed Tomography Upper Extremity; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73206	Computed Tomographic Angiography Upper Extremity With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73218	Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73219	Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73220	Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73221	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

73222	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73223	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73225	Magnetic Resonance Angiography Upper Extremity With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73700	Computed Tomography Lower Extremity; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73701	Computed Tomography Lower Extremity; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73702	Computed Tomography Lower Extremity; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73706	Computed Tomographic Angiography Lower Extremity With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73718	Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

73719	Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73720	Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73721	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73722	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73723	Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
73725	Magnetic Resonance Angiography Lower Extremity With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74150	Computed Tomography Abdomen; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74160	Computed Tomography Abdomen; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

74170	Computed Tomography Abdomen; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74174	Computed Tomographic Angiography Abdomen And Pelvis With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74175	Computed Tomographic Angiography Abdomen With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74176	Computed Tomography Abdomen And Pelvis; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74177	Computed Tomography Abdomen And Pelvis; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74178	Computed Tomography Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74181	Magnetic Resonance (Eg Proton) Imaging Abdomen; Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74182	Magnetic Resonance (Eg Proton) Imaging Abdomen; With Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

74183	Magnetic Resonance (Eg Proton) Imaging Abdomen; Without Contrast Material(S) Followed By With Contrast Material(S) And Further Sequences	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74185	Magnetic Resonance Angiography Abdomen With Or Without Contrast Material(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74261	Computed Tomographic (Ct) Colonography Diagnostic Including Image Postprocessing; Without Contrast Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74262	Computed Tomographic (Ct) Colonography Diagnostic Including Image Postprocessing; With Contrast Material(S) Including Non-Contrast Images If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
74263	Computed Tomographic (Ct) Colonography Screening Including Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
75635	Computed Tomographic Angiography Abdominal Aorta And Bilateral Iliofemoral Lower Extremity Runoff With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
77046	Magnetic Resonance Imaging Breast Without Contrast Material; Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
77047	Magnetic Resonance Imaging Breast Without Contrast Material; Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

77048	Magnetic Resonance Imaging Breast Without And With Contrast Material(S) Including Computer-Aided Detection (Cad Real-Time Lesion Detection Characterization And Pharmacokinetic Analysis) When Performed; Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
77049	Magnetic Resonance Imaging Breast Without And With Contrast Material(S) Including Computer-Aided Detection (Cad Real-Time Lesion Detection Characterization And Pharmacokinetic Analysis) When Performed; Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
77084	Magnetic Resonance (Eg Proton) Imaging Bone Marrow Blood Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S5501	Home infusion therapy, catheter care / maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S5502	Home infusion therapy, catheter care / maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9208	Home management of preterm labor, including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

S9209	Home management of preterm premature rupture of membranes (pprom), including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9211	Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9212	Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9213	Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately); per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9214	Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with s9326, s9327 or s9328)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

S9357	Home infusion therapy, enzyme replacement intravenous therapy; (e. G. Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9359	Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e. G. Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9372	Home therapy; intermittent anticoagulant injection therapy (e. G. Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with heparin to maintain patency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9373	Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes s9374-s9377 using daily volume scales)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9375	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9376	Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with home infusion codes for hourly dosing schedules s9497-s9504)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9590	Home therapy, irrigation therapy (e. G. Sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J1551	Injection Immune Globulin (Cutaquig) 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1554	Injection Immune Globulin (Asceniv) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5106	Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-Esrd Use) 1000 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5115	Injection Rituximab-Abbs Biosimilar (Truxima) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5119	Injection Rituximab-Pvvr Biosimilar (Ruxience) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5123	Injection Rituximab-Arrx Biosimilar (Riabni) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0219	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0485	Injection Belatacept 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J0491	Injection Anifrolumab-Fnia 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0517	Injection Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0791	Injection Crizanlizumab-Tmca 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1302	Injection Sutimlimab-Jome 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1303	Injection Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1305	Injection Evinacumab-Dgnb 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1306	Injection Inclisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J1823	Injection Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1930	Injection Lanreotide 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2353	Injection Octreotide Depot Form For Intramuscular Injection 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2354	Injection Octreotide Non-Depot Form For Subcutaneous Or Intravenous Injection 25 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2356	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2796	Injection Romiplostim 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J3032	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J3111	Injection Romosozumab-Aqqg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J3241	Injection Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J7183	Injection Von Willebrand Factor Complex (Human) Wilate 1 I.U. Vwf:Rco	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9332	Injection Efgartigimod Alfa-Fcab 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5109	Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
C9169	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
C9170	Injection, tarlatamab-dlle, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
C9399	Unclassified Drugs Or Biologicals	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0641	Injection Levoleucovorin Not Otherwise Specified 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J3490	Unclassified Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J3590	Unclassified Biologics	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9329	Injection, tislelizumab-jsgr, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9999	Not Otherwise Classified Antineoplastic Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1576	Injection Immune Globulin (Panzyga) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0172	Injection, Aducanumab-Avwa, 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0174	Injection, Lecanemab-Irmb, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J0175	donanemab-azbt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0218	Injection, Olipudase Alfa-Rpcp, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0223	Injection, givosiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0224	Injection, lumasiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0225	Injection, vutrisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J0589	Injection, Daxibotulinumtoxina-Lanm, 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1203	Injection, Cipaglucosidase Alfa-Atga, 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1304	Injection, Tofersen, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J1426	Injection, Casimersen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1427	Injection, Viltolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1429	Injection, Golodirsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J1747	Injection, Spesolimab-Sbzo, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2267	mirikizumab-mrkz	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2327	Injection, Risankizumab-Rzaa, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2329	Injection, Ublituximab-Xiiy, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J2508	Injection, Pegunigalsidase Alfa-Iwxj, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

J3247	secukinumab (intravenous)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J3393	Injection, betibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9333	Injection, Rozanolixizumab-Noli, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9334	Injection, Efgartigimod Alfa, 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
J9376	Injection, Pozelimab-Bbfg, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5133	Injection, Tocilizumab-Bavi (Tofidence), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999
Q5134	Injection, Natalizumab-Sztn (Tyruko), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

Q5138	ustekinumab-auub	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	1/1/2025	12/31/2999

Please note that checking eligibility and benefits and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of New Mexico (BCBSNM). For other services/members, BCBSNM has contracted with Carelon Medical Benefits Management for utilization management and related services.

Services performed without prior authorization, if required, will be denied for payment and providers may not seek reimbursement from BCBSNM members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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